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The Diagnosis of Extra-Uterine Prenancy.*

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The average practitioner rarely makes a diagnosis of extra-uterine pregnancy unless he finds an exsanguinated woman in a state of extreme collapse which has appeared soon after a sudden attack of severe abdominal pain. He does not attempt to make a diagnosis of extra-uterine pregnancy before either rupture or tubal abortion occurs, and for him the essential features of either of these conditions must always be those classical text-book symptoms of shock, caused by a profuse uncontrolled haemorrhage from a ruptured ectopic gestation.

As a matter of fact when the majority of extra-uterine pregnancies are first seen by the physician they do not present this typical text-book picture of collapse from concealed haemorrhage. The diagnosis is often obscure and can only be cleared up by a careful consideration of the patient's history coupled with a rigid physical examination.

If these two statements, which I have just made, be true, then

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there must be many cases of extra-uterine pregnancy in which the correct diagnosis is never made and the proper treatment never used.

I shall use but little time in trying to prove the truth of my first assertion. The majority of practitioners draw their ideas concerning the diagnosis of extra-uterine pregnancy from text-books rather than from actual experience. Formerly almost all of the text-books taught that extreme shock and collapse were nearly always the immediate, inevitable consequence of tubal rupture or tubal abortion. The discussion of the subject in most of the recent text-books also would give the reader a similar impression. Moreover, any gynecologist, who has had many consultations in obscure cases of extra-uterine pregnancy, must have been impressed by the conception of the average general practitioner regarding the symptoms of this condition.

My second postulate, that, contrary to this view, shock and collapse are not present in the majority of cases when first seen by the physician can also be substantiated, I think, by nearly every gynecologist who has given study to the subject of extra-uterine pregnancy, and who has had the opportunity of operating on a large number of these cases. The observations which I was enabled to make during a hospital residence service of over four years confirmed me in this belief, and the statistics of the operative cases which I have had myself during the last three years have supported it.

Out of seventeen patients on whom I have operated for extra-uterine pregnancy, but two presented the classical picture of shock and collapse. While some of the other patients were quite ill, none of them were in a state of shock when first seen. One patient sent to the hospital with a diagnosis of cervical laceration came in a day coach from a country town distant over one hundred and fifty miles. Others of them came varying distances, and many were able to walk to the hospital or to my office.

The diagnosis of extra-uterine pregnancy, therefore, is often much more difficult than the average practitioner supposes, or the average text-book would lead one to believe. In many cases the correct diagnosis can only be reached after the findings of a thorough physical examination have been compared with the subjective symptoms which a rigid cross-examination of the patient has elicited.

The diagnostic value of the various points which must be considered in studying a case of supposed extra-uterine pregnancy I can best discuss by analyzing my own series of cases with reference to the aid which each of these respective symptoms has given me in making the diagnosis.

My series consists of seventeen cases. Three of them were unruptured tubal pregnancies; six of them had terminated in tubal abortion; in seven the tube had ruptured with free haemorrhage into the general peritoneal cavity; and in one case the rupture had taken place into the broad ligament with the formation of an encapsulated haemorrhage.

In one case the diagnosis was not made, the finding of an unruptured tubal pregnancy on opening the abdomen being a complete surprise. In all other cases the correct diagnosis was made before operation.

The relative value of the various diagnostic points in the histories of these cases is as follows:

Repeated Extra-uterine Pregnancy.—It has often been stated that a previous ectopic gestation on one side predisposes the patient to a second occurrence of the same trouble in the other tube.

This may be so in one of my cases. This patient had the right tube and ovary removed for extra-uterine pregnancy three years before I operated on her for the same trouble in the left tube and ovary. While this point is not likely to be of value in many cases, still I believe that if the history of a previous extra-uterine pregnancy is obtained in a suspected case it would be of quite marked significance.

Previous Sterility.—It is usually stated that extra-uterine pregnancy occurs more frequently in women in whom the bearing of one or more children is followed by a certain period of sterility, this sterile period being in turn followed by the extra-uterine pregnancy.

I believe that this is of much diagnostic value. Fifteen out of my seventeen cases had borne children before the extra-uterine pregnancy occurred, and in eleven of these fifteen cases there had been a period of sterility for five years or more.

Pelvic Inflammatory Disease.—In accordance with the theory that chronic inflammation of the tubes is one of the causes of extra-uterine

pregnancy, is it often stated that an old history of pelvic inflammatory disease is of diagnostic value in such cases.

In ten of my seventeen cases operation proved that there had been no pelvic inflammatory trouble: five of them showed definite evidence of past trouble of this nature; and in two the conditions at operation were such that it was impossible to tell.

I conclude, therefore, that the past history of pelvic inflammatory trouble is of only moderate significance in making a diagnosis.

Amenorrhea.—An important diagnostic point is the fact that the patient has usually failed to menstruate at the proper time for one or more periods.

This was the case in fifteen of my patients. Two of the cases, however, had not missed a period. In one of these the last period ceased only sixteen days before the operation was performed. This was the case in which diagnosis was not made. The other patient was operated on twenty-four days after a normal period. The correct diagnosis was made before operation by consideration of the history and the physical findings.

Amenorrhea, when present, is of great significance in consideration with other symptoms. We must always be on our guard, however, for cases seen before it is time for the regular period and therefore giving no history of amenorrhea.

Character of the Pain.—The pain which is caused by a disturbance in the course of an extra-uterine pregnancy is often quite typical; its sudden occurrence, its intensity, and lancinating character are very significant. However, I have found that it is not always possible to get a history of this classical attack of pain. All of the seven cases of ruptured tubal pregnancy gave histories of typical attacks of pain. Of the six cases of tubal abortion but one complained of very severe pain. While all of the other five cases of tubal abortion complained of pain, in none of them was it very severe or the type of pain which we would expect to find.

This symptom, therefore, when present is of great value. However, we must not expect in every case to get a typical history of sharp pain with sudden onset.

Collapse.—I have already stated my views regarding the value of

collapse as a diagnostic symptom. In none of the cases of tubal abortion was collapse present when the patient was first seen by a physician. Five cases of ruptured tubal pregnancy with free bleeding into the peritoneal cavity had no collapse whatsoever. Collapse from concealed haemorrhage was present in but two of the entire series.

Nothing can be easier than the diagnosis of extra-uterine pregnancy when a sudden attack of severe cutting pain is rapidly followed by extreme collapse. But the most important point which I would urge in this discussion is, that the majority of the cases of extra-uterine pregnancy do not have the symptoms of collapse when first seen by the physician.

Bleeding.—I regard an irregular uterine haemorrhage as one of the most important single symptoms of this condition. It was present in all but two of my cases. The reasons that it was not found in these two cases are as follows: The first case was an unruptured pregnancy, the second case was seen in collapse but a few hours after the rupture had occurred and the ovum probably did not die until the rupture occurred. Every other case had uterine bleeding

Bleeding in this condition begins soon after the ovum dies. As this death of the ovum is often coincident with rupture or abortion, we find that bleeding usually appears soon after the onset of pain. This was the case in thirteen of the fifteen cases which had uterine haemorrhage.

Haemoglobin Estimation.—The presence of extreme anaemia is not necessarily limited to cases with collapse. One of my patients had a haemoglobin of 28 per cent at time of operation, although the rupture occurred one month before. In another case with a haemoglobin of 35 per cent, the rupture had taken place twenty-five days before operation.

The presence of extreme anaemia is of diagnostic value in obscure cases. However, I shall make no further comment regarding it as the haemoglobin estimation was not made in every case in my series.

Physical Signs at Abdominal Examination.—The physical signs obtained at the examination of the abdomen may, of course, vary much.

In seven cases the abdominal examination was entirely negative, neither tenderness, rigidity, or masses being found.

There was slight abdominal tenderness in seven cases. In all of

them the rupture had occurred several days before the abdomen was examined. Abdominal tenderness was extreme in three cases. It was distributed over the lower half of the abdomen, being more intense on the side of the rupture. Each of these three cases had ruptured tubal pregnancies with free haemorrhage into the abdominal cavity. Two of them had ruptured but a few hours before I saw them, and were in collapse at the time of examination.

Rigidity of the abdominal walls was present only in these three cases, which also had marked abdominal tenderness. It was extreme in the two cases in collapse.

Masses were found by abdominal palpation in five cases. In an encapsulated hematocele a mass was palpated above the symphysis. In a full term pregnancy the child was mapped out. The other three cases were all cases of tubal abortions. The distended infiltrated tube and the clots surrounding it formed a tumor which could be felt through the abdominal walls.

Physical Signs Found at Pelvic Examination.—Pelvic masses were found at the vaginal examination of each patient. This is the only sign which was present alike in every case. The mass was unilateral in ten cases; in the others the entire pelvis was more or less filled by a mass formed by the ectopic gestation and adherent blood clots.

It is pertinent to add that sometimes the tenderness is so great that no masses can be made out in the pelvis until an examination is made under anaesthesia.

Tenderness on vaginal examination is a variable symptom. In seven cases there was no vaginal tenderness, while in eight it was marked.

From the foregoing consideration it will be seen that there are no pathognomonic signs of extra-uterine pregnancy. Excepting the presence of a mass in the pelvis, there is no one sign which is invariably present in every case.

The diagnosis can often be reached only by carefully cross-questioning the patient as to all her symptoms, and then weighing all the evidence both for and against ectopic gestation.

The following is a fairly typical history of many of my cases:

A woman of 35, whose youngest child was 7 years old, failed to menstruate at her regular period. About six weeks later she was sud-

denly seized with an acute pain in the left side of the lower abdomen. The pain was severe and cutting and the patient was obliged to lie down. In a few hours the pain became less severe. It continued, however, off and on for ten days when I first saw her. The day after she had the attack of pain uterine bleeding began. This was not profuse, but had been constant. On examination a unilateral mass is found in the pelvis.

Now such a history as this is often not easy to get, especially if the woman is stupid, or of a phlegmatic or reticent disposition. In the first place she would complain mainly of the pain from which she is suffering at the time of consulting the physician, and would not give a good history of the acute character of its onset unless directly quizzed on that point. It is more than likely that she would fail to mention the period of amenorrhea and if she spoke of the bleeding, which came on the day after her pain, she would speak of it as the appearance of her menstrual flow. Hence a clear picture of symptoms in the proper chronological order could only be obtained by patient careful questioning on the part of her physician.

The most important symptoms are first a period of amenorrhea followed by a sudden attack of severe abdominal pain with vaginal haemorrhage appearing soon after the pain. If in addition a unilateral mass is found in the pelvis the great probability is that we have to deal with an extra-uterine pregnancy which has either ruptured or undergone a tubal abortion.

Diagnosis before rupture or tubal abortion occurs will, of course, only be made when some symptoms causes the physician to make a pelvic examination. In two of my cases the diagnosis was made before rupture. In each case the ovum had become loosened somewhat from the tubal wall and some blood had leaked out through the end of the tube into the abdominal cavity. The pain from the peritoneal irritation lead each patient to consult a physician.

This paper is already too long. The very interesting question of differential diagnosis I shall have to omit entirely, together with the detailed discussion of many other points.

I hope, however, that I have been able to make clear my point that the diagnosis of extra-uterine pregnancy is no simple matter. I be-

lieve that such cases are far more frequent than we suppose in many parts of the country, and that the number of cases which we recognize will vary directly with the amount of care which we put into the study of each suspected case.

Treatment of Puerperal Sepsis.

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Before entering upon a discussion of the treatment of any disease, the modes of prevention, or prophylaxis, should receive our careful consideration, and none should demand more attention than the causes of puerperal infection. Inasmuch as it has been demonstrated that the causes of puerperal infection are nothing more than the causes of wound infection in other portions of the body, our first thoughts upon entering the lying-in chamber should be those of asepsis and antisepsis; for it is little profit to a woman to render to her live-saving assistance during the trying hours of child bearing, and at the same time inoculate her with germs which may subsequently produce disease and death. The obstetrician should follow the same rules (so far as it is in his power) as to surgical cleanliness as he would were he performing some major operation on the same patient; hence it follows that the hands of the attendant should receive the first attention, and second only to this the perineum of the female. While it has been proven by experimentation that it is impossible to render the hands sterile, we can remove this danger of infection by thoroughly cleansing the hands and wearing rubber gloves during each vaginal examination, which should be as few as possible, or not at all if the attendant is expert enough to determine the position and presentation from a careful examination of the abdomen. Personally, I am far from this stage of perfection. The patient should have a thorough bath as soon as the approach of labor is recognized, and this should be in the form of a shower bath if it is available, thus obviating the danger of some of the infected water of the bath tub entering the vagina. The physician

should have the perineum and thighs of the patient thoroughly washed in soap and water, followed by a solution of bichloride of mercury before the examination, and it is better to place a pad soaked in this solution over the vulva. The vagina itself should be left entirely to nature, using no antepartum douches. Tears of the perineum of any extent should be at once closed, for by doing away with the raw surfaces you diminish the liability of infection. A frequent cause of infection is the rapid delivery or tearing away of the placenta. The separation of the placenta, being a physiological process, should be left to nature, unless some cause arises to give reason for its rapid delivery. An exercise of patience for fifteen or twenty minutes with careful watching will usually be sufficient for this purpose. After this the placenta may be removed by Crede's method, carefully twisting the membrane after the body of the placenta has been delivered.

Treatment.—There is a great diversity of opinion regarding the treatment of puerperal infection, but in some of the main features all agree, namely, upon stimulation and feeding. In all forms of infection the necessity of giving very nutritious and easily digestible foods with free stimulation is obvious, and especially does alcohol seem to act beneficially in infection of this kind.

As soon as there is a rise of temperature with an increased pulse rate, we should consider we have a case of infection with which to deal, provided we can rule out other intercurrent diseases. We should at once institute search for the location, which may be found in a slight tear of the perineum which has escaped our notice, or it may be a general inflammation of the vaginal mucous membrane. In the former case, the application of carbolic acid, and in the latter, a free application of the tincture of iodine will often remove the trouble, and the fever will at once subside. Should the infection be within the uterine cavity we should obtain a specimen of the lochia and submit it to a bacteriological examination, determining the kind of infection we are dealing with; after which we thoroughly cleanse the uterine cavity by free irrigation with sterile water or salt solution, and apply tincture of iodine to the endomentrium. Iodine will penetrate deeply into the uterine tissue and perhaps destroy many of the micro-organisms present. Within a few hours after the application of tincture of

iodine, the free iodine can be detected in the urine, thus showing its penetrating power. This accomplishes the same purpose as packing the uterus with iodoform gauze, advocated by many, and at the same time does not inhibit drainage, or leave an irritant in the uterine cavity.

The employment of the curette in puerperal endometritis is positively contra-indicated for the following reasons: First, because there is nothing to be curetted away; secondly, because by this means nature's protective wall of leucocytes is broken down, giving a free and unobstructed route for the deeper invasion of the tissue by the organisms. After once the uterus is clean, there is no use for further douching, unless we have a putrefactive process present and a foul smelling discharge, when a douche of permangnate of potash will prove of service.

The douche of bichloride of mercury and carbolic acid have been said by eminent authorities not to be devoid of danger, and as there is little to expect from their antiseptic qualities, as they do not penetrate the tissues deep enough to come in direct contact with the cause of infection, their use is contra-indicated. Bumm demonstrated this fact by taking the liver of an animal dying of anthrax and immersing it in a 1 to 1000 bi-chloride solution and leaving it there for thirty minutes, then placing a portion of this on a freezing microtone, and cutting away only one-tenth of a millimeter, he inoculated the next section into another animal which promptly succumbed to anthrax, showing the germicidal properties had only been exerted on the surface. This being the case with a dead organ in which we have no circulation underneath, how can we expect anything from our germicidal douches where we have the lymphatic and blood streams flowing constantly, and should our solution penetrate the tissue at all they would at once be carried to distant parts.

Ergot, given with a view of causing contraction of the muscular tissue, thereby occluding the greater number of the lymphatics of the muscular wall, is of theoretical value, but the effect on the circular fibers is such that should there be any drainage or discharge, it will have a tendency to dam the secretions in the uterine cavity.

Should the infection be of streptococcic origin, the serum may prove

of value. I have employed this in several cases, and I fancy that I got benefit from its use. Kelly says: "The use of antistreptococci serum, proposed in 1895 by Marmorek, has been disappointing. Williams relates that in May, 1899, a committee of the American Gynecological Society, of which he was chairman, made an exhaustive report of this subject, giving the complete literature and collecting all of the cases. They found that in 352 cases of puerperal infection there were 73 deaths, a mortality of 20.74 per cent. In a large number of these cases it was not positive that the cause of the infection was the streptococcus, but in 101 in which the streptococcus was demonstrated 33 deaths occurred, a mortality of 32,69 per cent. According to Edgar, the method is still on trial and it may be used. He says that it is necessary to exhibit the remedy in large doses. The initial injection should be 20 c. c. while the daily dose should be 60 c. c. in desperate cases. According to J. S. Evans, the initial dose should be 80 c. c.; this should be repeated every six hours until 320 c. c. have been given during the first twenty-four hours. The serum can be used scientifically only when a bacteriologic examination of the uterine contents or an examination of the blood has proved the streptococcus to be present. In desperate cases, as the serum apparently does no harm, it may be tried."

Intra-venous injections of salt solution or hypodermoclysis is useful as it dilutes the poisons, causes free diuresis and diaphoresis, and acts directly as a heart stimulant. Recently, in consultation with two other physicians in a case of puerperal infection, in which the pulse was 170 and with a high temperature, we used 1500 c. c. of intravenous injection, followed by prompt improvement. As the case would show signs of growing worse, we would resort to hypodermoclysis, and in this manner the patient was tided over the crisis and restored to health.

Quinine may be used to combat the high temperature, unless the effect on the stomach is such as to interfere with nutrition; then its use is contra-indicated.

Hysterectomy is advanced as a surgical means in the treatment of puerperal infection, but from the fact that some severe cases go on to recovery, while others mild in the beginning, terminate in early death,

the time to resort to this heroic treatment is hard to determine. I have operated upon twelve seemingly hopeless cases in which I removed the entire organ, and eleven of these recovered. In each case, I think, the condition was seemingly hopeless, as most of the uteri removed were perfectly necrotic. It is very important to do a complete or panhysterectomy, otherwise a necrotic cervix is left which is an excellent incubator for the production of micro-organisms. This condition is just what causes so many fatalities in suppurative processes in the abdominal cavity. We get a necrosis of some large piece of tissue or organ and nature can not invade this stronghold to attack the enemy. We no longer fear a contaminated peritoneum as we used to, for we know with proper treatment that if the infection is such that nature can get at it the chances are good that the resistance will overcome the infection. I have no desire to place myself on record as favoring the promiscuous removal of uteri in infection, but when every other means is seemingly exhausted, then is the time for the adoption of this heroic measure. The length of time consumed in doing this operation is of great importance, as you do not wish the patient to suffer from a long continued anaesthetic nor the shock incident to a long drawn out operation. After the operation I think the after treatment is of no less importance, for we have a patient whose blood is loaded with organisms and their toxins. No better treatment could be used in this condition than the Murphy-Fowler, that is, elevating the head of the bed, and giving large quantities of normal salt solution by bowel, skin or vein. To this may be added whiskey, if one prefers. Also, the patient's kidneys should be stimulated by spartein sulphate in one grain doses hypodermatically, together with strychnine in proper cases.

As soon after operation as possible, which is usually 48 hours, we should secure a movement of the bowels, after which we can feel our patient is practically out of danger and on the high way to recovery.

The Sanitation of Small Cities.

By H. G. Perry, M. D.,

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Mr. President and Members of the Chattahooche Valley Medical and Surgical Association:

I wish to express my appreciation of the honor of addressing this association, which has for its object the betterment of the condition of the human race.

The subject which I have chosen is one which is of first importance, both to the medical profession, and to the laity. Fourteen hundred years before Christ the most explicit laws for personal and community hygiene were given by Moses, and the people murmuring in the wilderness because of bitter water. Moses was directed to put the branches of a certain tree in the water to sweeten it. In the eleventh century an extended treatise on water was written by an Arabian physician, Ebn-Rodoman. He recommended taking the water of the Nile, where the current was swiftest, and the water contained the least decomposing matter, allowing the foreign material to subside, decanting the clear water, and further purifying it by means of heat, filtration and the addition of certain aromatics. These things show us that the ancients were awake to the necessity of a pure water supply.

Much has of recent years been said and written, many experiments carried on, some lives even sacrificed in the interest of science as it relates to the prevention of disease. Large cities have spent millions in the erection of magnificent water and sewerage systems, and in the destruction of disease breeding insects. Very little practical work has been done in the interest of the smaller towns. That much needs to be done will be the testimony of all thoughtful men.

The object of all government is to secure to those governed the most favorable circumstances under which to live. "Life, liberty and the pursuit of happiness" as set forth in the declaration of independence. The first consideration of government is the conservation of the lives of its subjects. Without health, life is, at best, a vain show, and liberty and happiness impossible. So I contend that sanitation, which is

"the establishment of conditions favorable to health." should be the highest duty of government.

The apathy shown by the authorities of the smaller towns in dealing with the subject is due more to ignorance of the right principles of living, and to the many false ideas which have come to them through tradition, than to indifference. It becomes our duty as conservators of the public health, to enlighten the people. This can be done by lectures to schools, societies and clubs, by persistent appeal to municipal authorities, and by priviate instrucion day by day as we go in and out of the homes of the people.

I have no new word to bring, no startling innovations to offer in this communication, but I wish to insist upon the application to the smaller towns, of the same principles of sanitation which govern in well regulated cities. I would urge the point that with such modification as local conditions demand, these principles are universally applicable. Just here let me remark that I favor municipal ownership of public utilities. The question of municipal finance is quite a different proposition to that of personal economy. It should be the aim of the individual to provide a surplus against the contingencies of the future. A municipality, on the other hand, should have no surplus, but wisely and economically should expend all of her income for public betterments. Any town of 1,000 inhabitants, or above, should have no trouble in raising enough revenue by equitable taxes and licenses to pay all the ordinary expenses of government, and also interest on bonds sufficient to build and equip water, light and sewerage systems.

In this day, when such easy access is to be had to efficient laboratories, there is no excuse for any town or any individual taking risk as to the purity of the water supply. No town should be so careless as to install a water system until the purity of the water has been fully tested, nor if the system is already in operation, should any town be content with an uncertainty as to the maintenance of the most perfect conditions.

"Ready methods for determining the quality of water have always been in great demand. But a reagent which will strike a brilliant color in a non-wholesome water, while it leaves a wholesome water clear

and colorless, forms one of the unrealized dreams of the ameture sanitarian."

While it may be truly said that laboratory analysis is necessary to establish with absolute certainty, the status of water, yet the practitioner and health officer should familiarize himself with the physical manifestations of pure and impure water. First should he consider the general characteristics as they appeal to the sight, taste and smell. Water should be examined in a clean, clear glass vessel. Pure water has a bluish-gray tint. A green color indicates contamination with vegetable matter. Light brown or yellow is due either to the presence of sewage matter or may be due to iron salts. The purest waters are clear, bright and sparkling. However, polluted water from surface wells or shallow springs may have the same characteristics. Polluted waters generally have a disagreeable taste, but if the solids are well dissolved, and the water well ariated, this may not be true. Iron in very small quantities can be tasted but other salts cannot be tasted unless present in larger proportions. In order to arrive at definite conclusions as to the odor of water, a specimen should be put into a stoppered flask and gently warmed. Gases indicative of fermentation and putrefaction are thus released. If the flask be kept in a warm place for a few days, it will afford time for the development of bacteria. If such be present there will be more or less turbidity. Very small amounts of organic matter will condemn a water. Of minerals, more than twenty-one grains to the gallon is considered detrimental to a water for general use. Many of our mineral springs contain amounts in excess of the above, but while their therapeutic value is unquestioned, these springs would not furnish a good source of public water supply. If a town depends upon shallow wells, which no thickly populated town of a thousand inhabitants should do, special care should be had that no surface water flows into the wells, and that no stables, closets, drain or sewer pipes be maintained within a distance from such wells of twice their depth. Wells should also be covered and screened. Shallow wells form a dangerous source of supply in localities which have been occupied for some time. The accumulated filth of continued settlement drains through the surface layers, contaminating the water. Percolation may eliminate the coaser elements of decaying matter, but germs

of specific infection may pass into the well and the water be rendered unfit for use.

By having a pure water supply a municipality may reduce to a minimum if not entirely suppress such diseases as cholera morbus, diarrhoea, dysentery, enteritis, gastro-enteritis and typhoid fever. It should be the constant aim of the health officer to impress upon the people the fact that these diseases are water borne, and that they can be prevented.

In a town supplied by wells, a careful supervision of the handling of refuse is much more important than if the town had a water system. In the first instance, we have many sources of possible contamination, while in the latter, we have only one. Just in proportion as wells are multiplied, the problem of maintaining a pure water supply is complicated. In no towns should refuse matter be allowed to accumulate on the streets or on individual premises. Especially should strict inspection and frequent removals be demanded from frost to frost. The trifling costs to cities or individuals is many times overpaid by freedom from disease. Cess-pools are to be deprecated under any circumstances, but in a well water town they should never be allowed. Strict but reasonable sanitary rules can be worked out and put in operation, which will insure the proper disposal of all refuse.

Where a good system of water-works has been established, the questions of drainage and sewerage are much simplified. Here, being sure of the source, the main proposition is to so dispose of waste waters that no standing pools be left to form breeding beds for mosquitoes, and that no source of drinking water for man or beast in the surrounding country be contaminated.

The sewerage question is difficult to handle in both small and large cities. The idea that it is safe to discharge liquid sewerage into running streams is fast losing adherents. Sewerage farms have been demonstrated to be the most practical, economical and sanitary method of disposal. Wherever tried they have proven sources of income. Hence I say that they are applicable to small, as well as to larger cities.

There are annually within the United States 35,000 deaths from typhoid fever, and more than 350,000 cases of this disease. When more than one case occurs in a family or neighborhood somebody is

to blame. It is within the province of the health authorities to demand of physicians attending such cases that all known precautions be taken.

Great care should be had to drain or oil standing water in order to prevent the breeding of mosquitoes. Screening of dwellings and frequent removal of manure piles should be encouraged to the end that the fly may be banished.

A feasible plan for the inspection of slaughter-pens and markets in small towns has not, to my knowledge, been satisfactorily worked out. May I express the hope that our efficient State veterinarian may be able in the near future to solve this problem.

However, every town should have an ordinance requiring hoof inspection of all animals to be slaughtered, and also regulations requiring that meat exposed for sale should be protected from flies.

I would not be guilty of assuming that this intelligent assembly is in need of any word of information I may bring upon the fight being made throughout the land on "the great white plague." That this war on the greatest single cause of death will be of much benefit to us in our efforts against all air-borne diseases, does not need argument. Every town should have an anti-spitting ordinance, conscientiously enforced for the education, and not for the oppression of the people.

The people should be taught that bronchitis, diphtheria, influenza, measles, scarlet fever, whooping cough, pneumonia and consumption are air-borne, and to a large extent preventable.

In that remarkable novel "Looking Backward" Mr. Bellamy describes a city entirely covered in with glass. Air, rendered germ-free, is pumped in and out by the most perfect system. Water, sterilized, and all sources of disease thoroughly controlled. The inhabitants are so well taught in the principles of living that sickness is wellnigh unknown. No hospitals, prisons or asylums are needed. These conditions will never be realized. As long as man lives he must live under the curse. But if the medical profession will but practice that altruism taught by the fathers, and if the people will respond to our teaching, preventable diseases will soon cease to afflict humanity, and we can confine our ministrations to assisting our friends into and out of the world, and to operations upon the appendix.

Auto-Intoxication or Biliousness.*

By E. P. Lacey, M. D.,

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Auto-intoxication or biliousness is not a disease, but a condition which may terminate in organic change, as persistent functional troubles frequently lead to structural defects.

Neither of these conditions are definite clinical entities as there are so many modifying influences, the symptoms observed at one time are decidedly different from those presented at another, and especially is this true of auto-intoxication.

Do these two conditions exist independent of each other or are they so closely related as to be inseparable?

If we accept the broad interpretation of auto-intoxication, as poisoning oneself, which may emanate from a number of sources, while biliousness implies a failure of the liver to perform its function and especially to secrete bile, the two terms should not be used synonymously. The contention that biliousness is an indefinite term applies with equal emphasis to auto-intoxication. The latter term conveys no knowledge of cause or origin, but is a broad one applied to a number of conditions which may arise from different sources.

It should be constantly borne in mind that all cases of auto-intoxication are merely symptoms, "effects of definite causes known or unknown, and if considered merely as are other symptoms, errors of interpretation will be less common." Every case should be carefully studied with a view to determining its cause, and if it is ascertained it should be removed when possible, but the clinical manifestations are so numerous, it is frequently difficult to locate the cause.

The most frequent sources of auto-intoxication are the gastro-intestinal canal, the liver and the kidneys.

Under the head of intestinal cases fall those due largely to putrefaction of the proteid content of the food. The splitting up of the proteid malecule by putrefactive fermentation in the intestine, produces a number of poisonous substances. Among these are indol, skatol,

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*Read before Jefferson County Medical Society.

phenol, carbon dioxide, marsh gas and hydrogen sulphide At birth no bacteria are found in the intestinal canal and Senator says, indican does not occur in the urine of infants which have not taken food. Bauman, after disinfecting the intestinal tract of dogs with calomel, observed that all traces of it disappeared from the urine, which leads to the conclusion that putrefactive organisms are always concerned in its production.

In health the large intestine is the sole source of indican, but proteid putrefaction and bacterial fermentation occur normally in the gastro-intestinal canal at all times, and it appears that it is only when these processes transgress certain bounds that they become detrimental to the organism. In fact, their presence is so constant the question has been asked whether or not they are essential to nutrition. The consensus of opinion is that they are not essential.

Some of the products of proteid metabolism are very injurious, and the symptoms are very similar to those of biliousness. Wood is authority for the statement that the administration of small doses of indol will produce lassitude, headache and other symptoms characteristic of so-called bilious attacks.

One of the end products of the nitrogen content of proteid metabolism in the intestine is ammonia compounds which are converted by the liver cells under normal conditions into urea, which enters the general circulation an innocuous substance, and is finally eliminated by the kidneys. When this conversion does not take place free ammonia enters the systemic circulation and may accumulate in sufficient quantity to produce auto-intoxication of a serious nature.

Another class of substances known as the menclins, which represents the cells of the food and body, break up into a number of compounds known as the alloxur or purin bases. The most prominent of these are xanthin and hypoxanthin, which on oxidation are converted into uric acid. At one time it was thought uric acid was the cause of gout and rheumatism, but the impression now prevails that it is sub-oxidation, or a failure of these substances to be converted into uric acid that causes the trouble. To support this theory is the fact that "a considerable diminution in the quantity of uric acid is noticed immediately preceding an attack of gout, and immediately following it an increase is observed."

Dr. Crofton, of Chicago, working along the line of experimental study was able by the administration of the alloxur bases, xanthin and hypoxanthin to induce increased blood pressure, with arterial spasm, thickening of the arteries, hypertrophy of the heart and granular and fatty degeneration of the kidneys.

He is of the opinion that high arterial tension is one of the "determining features of Brights disease," and that auto-intoxication, due to poisons generated in the intestinal canal, and the liver cells fail to convert them into harmless substances, they enter the general circulation and are one of the principle sources of the cardie-vascular changes which constitutes that disease. He does not use the terms Brights and nephintis synonymously, as the former is one of the causes of the latter, or in other words he speaks of the nephintis of Brights disease.

The nervous system is not immune to these poisons, but the sensitive cells of the young, and of those of unstable nervous organism, respond in a violent way to the injurious effects of the toxins from the intestinal canal. In those who are the victims of epilepsy it has been observed that the attacks increase when meat, or food containing a large amount of proteids is taken, and that there is an immediate diminution in the number of the attacks when such food is withheld. There is an increased diminution of urea following true epileptic convulsions which leads to the belief that the ammonia compounds accumulate previous to the attacks, and are the inciting causes of the seizures. In mental diseases a diminished excretion of urea has been observed in melancholia, and the happy results which occasionally follow eliminative treatment, sustains one in the belief that such cases are due to auto-intoxication.

Some of the products of bacterial putrefaction resemble the alkaloids in their physiological action. I am of the opinion they are the cause of cholera morbus, which follows indulgence in large quantities of indigestible food.

What agent keeps the bacteria of decomposition within bounds and protects the organism from a constant state of auto-intoxication? Bacteria are always present both in the large and small intestine, but only those capable of fermenting carbohydrates show any decided activ-

ity. Howell says putrefaction of proteid material is limited or absent in this part of the intestine as long as the products of proteid digestion are promptly absorbed. Conditions that prevent or retard this absorption favor the occurrence of proteid putrefaction. The theory is advanced that organic acids are formed during carbohydrate fermentation which inhibit the action of the proteid bacteria. Intemperance in eating, when the quantity of food taken is so large as to preclude the possibility of its digestion, is a frequent cause of auto-intoxication. Every physician has been called to attend cases following a night of revelry, when food and spirits had been taken in excess. The ignorance of the laity in regard to eating is remarkable. They think three meals a day is essential to the preservation of life regardless of the condition of the stomach.

The kidneys are purely excretory organs. They have only one function, the excretion of urine, which holds in solution many substances injurious to the system. It is not the retention of any particular constituent of the urine in the blood which is responsible for that form of auto-intoxication known as uremia, but a retention of the whole. The composition of the urine is modified by a great many conditions, viz: the health of the individual, the food, both quantity and quality, various drugs and the weather. This channel of elimination should be kept open if possible, for when the function of the kidneys is suspended, death is inevitable in a very few days. When we consider the manifold functions of the liver we must admit it is one of the most important organs of the body, as functional troubles constitute the major part of a physician's work. All its functions are essential to the well being of the organism. It is not reasonable to suppose that they "go on forever" without interruption, then why not call the suspension biliousness? If a term can be used which calls one's attention to the particular organ involved, it is better than to use one which does not, therefore, I consider biliousness appropriate for functional liver troubles.

Auto-intoxication has no special reference to the liver, as the source of the trouble may be in the gastro-intestinal canal or kidneys. Whether in attacks of biliousness there is a suspension of all the functions of the liver, I do not know, but there is a failure to secrete bile, as its ab-

sence is noticeable in the feces. Bile is both a secretion and excretion, as it eliminates the waste products of cholestorim, lecithin and bile pigments. Cholestorium is regarded as one of the waste products of cell life; lecithin is found in the white matter of the nervous system, and bile pigments originate from hemoglobin. Waste and decay are one of the characteristics of all living things, and when effete products accumulate in the system as a result of faulty elimination, all vital functions are disturbed, the process of decay is stimulated, hence the necessity of a close observance of all organs of elimination. Other functions of the liver are the formation of glycogen, the digestion and absorption of fats, and it aids in the prevention of putrefaction and fermentation in the intestines. "It is recognized that while normally bile is not a germicide, it does inhabit putrefaction in the intestine." Confirmation of this theory is the fact that drugs which increase the flow of bile are usually followed by a relief of the symptoms of auto-intoxication. I have heard it stated that any drug which creates penstalsis will produce a secretion of bile, but this is contrary to my experience and observation. There is a difference between the secretion of bile and its injection or discharge into the bowel. The former under normal conditions is constant, while the latter is intermittent and follows the entrance of food into the duodenum.

How is biliousness recognized? By the symptoms, the most prominent of which are headache, loss of appetite, constipation, nausea, a brown coat on the tongue and frequently inability to sleep. There is a difference between this condition and auto-intoxication, from the fact that intestinal antiseptics which do not act on the liver will not relieve the patient. When calomel has only a purgative effect it is barren of results when administered in cases of biliousness. The action of this drug on the liver has occasioned much controversy, some asserting that it is not absorbed and acts only on the excretory glands of the small and large intestine. Investigators who have studied the excretion of drugs claim they have found calomel in the bile in the gall bladder, which, if correct, is conclusive evidence that it is absorbed and acts on the secretory cells of the liver. Clinical medicine sustains the contention that it is a chologogue.

Hepatic insufficiency is a frequent cause of auto-intoxication from

the intestinal canal. The liver stands as a barrier to protect the "fortress of life" from an invasion from this source, and when its defenses, the liver cells, are weakened from any cause, toxic substances from the intestines, "flood the liver channels where they should normally be arrested or disinfected," still further injuring the efficiency of any already crippled organ, and completing the closing of a vicious circle.

Biliousness is a term which is rejected by some physicians as unscientific and indefinite. "Whatever it means to our several minds" it should be applied only to functunal troubles of the liver, and surely none will contend that it always functionates. It is immaterial what is the trouble with our patients, there will be no improvement as long as the liver fails to act.

Fortunately the treatment for auto-intoxication and biliousness is very nearly the same, dieting and elimination. Calomel and starvation are the principle remedies.

THE VARIETIES OF DYSMENORRHOEA.

In an article on Dysmenorrhoea, Solomon Henry Secoy, M. D., of Jeffersonville, Ind., refers especially to its causes and treatment and offers some valuable suggestions as follows: "I am in the habit of regarding dysmenorrhoea as capable of division into three varieties. They are the neuralgic, the obstructive, and the membranous. The neuralgic form is a pure neuralgia, and its subjects, in all cases, will give a history upon which we can base its cause. These patients will tell us that never, prior to the attacks which they have recently undergone, have they had dysmenorrhoea. It is caused generally by malaria and other influences which tend to lower the general health.

"The treatment of dysmenorrhoea very naturally comprises such remedies and procedures as will correct the cause, and the administration of anodynes to relieve the pain. In the neuralgic form we must correct the cause. If that be malaria, quinine must be given. In most cases where the neuralgic form is presented there is anemia, and no relief will be secured till this factor is overcome. Iron in some available form must, therefore, be given. During the period of menstruation the administration of antikamnia and codeine tablets in doses of two tablets every two hours, will relieve the pain. If these tablets are given at the beginning of the attack, we can often entirely prevent pain."

Society Reports.

American Proctologic Society.

Tenth Annual Meeting held at Chicago, Ill., June 1 and 2, 1908.

The President, Dr. A. Bennett Cooke, in the chair.

Officers elected—President, Geo. B. Evans, M. D., Dayton, Ohio; vice-president, John L. Jelks, M. D., Memphis, Tenn.; secretary-treasurer, Lewis H. Adler, Jr., M. D., Philadelphia, Pa.;

Executive Council—A. B. Cooke, M. D., Chairman, Nashville, Tenn.; Geo. B. Evans, M. D., Dayton, Ohio; Samuel T. Earle, Jr., M. D., Baltimore, Md.; Lewis H. Adler, Jr., M. D., Philadelphia, Pa.

The place of meeting for 1909 is Atlantic City, N. J., May 31 and June 1, 1909.

The following were elected members of the society: Dr. Geo. W. Combs, 235 N. Penn St., Indianapolis, Ind.; Dr. Alois B. Graham, 224 N. Meridian St., Indianapolis, Ind.; Dr. Arthur Hebb, Professional Building, Baltimore, Md.; Dr. Alfred J. Zobel, 352 Lake St., San Francisco, California.

The following is an abstract of the principal papers read:

PRESIDENT'S ADDRESS.

The president, Dr. A. Bennett Cooke, of Nashville, Tenn., after briefly reviewing the organization and early history of the society, stated that there has probably never been a medical organization composed of a membership drawn from such widely separated localities and so restricted as to number, which can show a similar steady and unbroken record of growth, enthusiasm, and interest, increasing with each succeeding meeting. The fidelity and devotion of the individual members was in the beginning and has remained the society's distinctive characteristic.

He then proceeded to trace some of the results which had been accomplished in the ten years of the society's existence, chief among which was emphasized the assured position as a legitimate dignified and important specialty which is now universally accorded to proc-

tology. "Ten years ago special instruction in this branch, with a few exceptions, was only to be had in the post-graduate institutions of the larger centers. Today the curriculum of any medical college which does not include a course on proctology is rightly considered to that extent defective and behind the times. The benefit of this new order of things to the public can not be estimated. At the present time the average patient requires something more of the man who is to be entrusted with his case than the title of "M. D.," and as a direct consequence instances of incorrect diagnosis and misdirected treatment have become notably fewer."

The objects of the society as defined in its constitution are the acquiring and dissemination of knowledge relating to this special field. The speaker inquired if the society was living up to the full measure of its possibilities in regard to the second object, i. e., the dissemination of knowledge, arguing that such was not the case. As the means of correcting this defect, he suggested:

1. That an official organ be adopted or established and a full report of the scientific proceedings of each meeting published.

2. That the possibility and advisability of becoming a section of the A. M. A. be seriously considered. The advantages and disadvantages of the latter suggestion were fully discussed, the opinion being expressed that what the society would lose in independence and individuality would be more than gained in the wider sphere of influence and usefulness opened up by this more liberal policy.

The real question is not what we as individuals prefer, but what course would most certainly conduce to the advancement of the highest purposes of our organization? For after all we must remember that we are physicians before we are specialists, and that our most imperative duty has reference to the interest of our profession as a whole and to the welfare of humanity for which alone it exists.

"THE TREATMENT OF CHOICE OF STRICTURE OF THE RECTUM"

was the title of a paper by Wm. M. Beach, A. M., M. D., of Pittsburg, Pa., who stated that in his early proctologic experience he became an enthusiastic on this or that method of treatment only to be disappointed

by a recurrence of the ailment. All the classical recommendations were tried, namely, gradual dilatation, proctotomy internal and external excision and a few other technical schemes, ideal but not practical. Each promised favorable results for a time, but experience taught him that instead of cure the condition uniformly became worse.

In order to answer the query, what is the choice of treatment, it is important to consider first the history of syphilitic stricture and second, the location and form of stricture to determine the degree of obstipation, third, the effect of a rectal stricture is to induce obstipation and extreme dilatation of the colon Moreover, immediately above the various constructions are found the active ulcerations, the source of profuse discharges of pus, blood and mucous. Among other symptoms may be found colicky pains in abdomen—distension of abdomen, backache, aching down the legs, loss of flesh, and withal a general anxiety and neurasthenia.

Regarding the treatment it is apparent that if the disease was seen early much could be done to avoid disastrous consequences, but as the disease is so insidious in onset and development by virtue of the fact that the trouble is usually located in painless area, and that nothing short of obstipation drives the patient to seek advice, it is obvious that palliative treatment only increases the irritation and produces a great degree of stricture. For this reason the injections of fluids is needed only for cleansing purposes and such procedures as gradual dilatation by the passage of bougies, forcible divulsion, proctotomy, and even excision are only temporary.

For these reasons the author concludes that a permanent colostomy is the preferable plan as this procedure admits of direct irrigation of the rectal cavity. The administration of strontium iodide in ascending doses for interrupted periods the writer believes is of extreme value, but he states that he has never been able to destroy the syphiloma with its use.

Irrigation should be used daily for the first month and less frequently thereafter. For this purpose normal solutions should be used of salines alternating with solutions of one to one thousand permanganate of potash, or nitrate of silver twenty grains to the quart, or of ichthyol a drachm to the quart. Boracic acid solutions are often beneficial.

Defecation through a properly constructed inguinal anus is complete painless and under reasonable control. The patient soon becomes reconciliated to his condition and rapidly improves in health.

The author from his experience concludes his paper with the following remarks:

1. Syphilitic stricture of the rectum is believed to be the result of badly treated cases of syphilis in the early stages.

2. It is more frequently found in the female, for the reason that the primary lesions are more apt to be overlooked.

3. Direct surgical attack of rectal syphiloma does not insure permanent relief, but rather aggravates the condition.

4. Specific constitutional treatment should be instituted, with the hope of making a favorable impression upon the diseased tissue.

5. Permanent colostomy is the treatment of choice for the purpose of irrigation and restoration of bowel functions.

"AMEBIASIS, ITS SYMPTOMATOLOGY. DIAGNOSIS, SEQUELAE AND THE USE OF FORMALIN AND COPPER PHENOL SULPHONATE IN THE TREATMENT.

By Dr. John L. Jelks, Memphis, Tenn.

Who called attention to the great prevalence of this disease in the South. Marked differences have been ascribed to the ameba as to its character and actions in different cases, especially with reference to their phagositic properties and their motility. The author referred to associated infection as playing an important role in many cases and attributes to this mixed infection, the difference in character of ulceration in the higher parts of the colon, and that in the rectum.

Cases of amebiasis are referred to as occurring in nests, in the low marshy districts, in the sparcely settled alluvial sections and in the suburban mill districts of the city None of the cases in the city were residents of the highland portion and all of them partook of fresh vegetables which were grown in the bottoms and washed with water from shallow wells.

The author viewed with suspicion all cases of violent acute dysentery or chronic diarrhea with mucus discharge. The author stated with emphasis that he has not found the symptoms of dysentery and diar-

rhea, essentials to the existence of amebiasis; on the other hand, he has encountered cases in which constipation or obstipation was complained of, and he called special attention to this statement as being contrary to the general accepted theory.

In the majority of cases, however, he states the patient complains of and the predominant symptom in chronic cases is, that of recurring diarrhea, which has existed for several months or years, associated with a quantity of mucous and occasionally blood stained.

The symptoms in malignant acute cases, the author recited, are quite severe from the onset, the patient suffering great exhaustion from numerous movements and the septic condition which soon ensues Sometimes large casts of mucosa are expelled, as also casts of mucus and fibrin. These latter are most fatal and should they recover from the acute symptoms, very often lapse into a sub-acute or chronic condition which may last for years with periods of abatement and exacerbation of symptoms.

The author reviewed the symptomatology and stated that a diagnosis might be overlooked without the aid of the microscope, which if put into more general use by clinicians in the South, especially, would reveal many heretofore unsuspected cases as of this origin.

In reciting the sequelae and gross intestinal pathology in a series of twenty-five cases, the author referred to many features. and stated that in two recently treated cases, small openings or ulcers extended into extensive sub-mucus abscesses.

Often the intestinal mucosa presents only slight ulceration, or a general red granular appearance, or perhaps oedematous, and though these are amebic, a mixed infection is thought accountable for certain phases of this process, for, as the author explained. the amebae prefer the juicy sub-epithelial structures, and the pathology is chiefly sub-epithelial. The colon bacilli and streptococci are accorded importance in part of the inflammatory process, especially in the rectum. Thus is explained the great difference in the character of the ulcer found there and those seen in the higher portions of the colon.

Autopsy in one case showed marked strictures and thickening of rectal wall, while in the splenic flexure, which was the seat of fatal perforative ulceration, the ulcers were sharp cut, round and oval seen

through a thin gut with only lightly adherent omentum covering the perforated gut.

Periods of exacerbation and abatement of symptoms in these chronic cases are thought due to several causes, chiefly the difference in activity and virulence of different generations of this protozoa. Certain differences exist also in activity in sporulation and in the process of incistation.

In the twenty-five cases cited by the author he noted four cases in which infection in the liver was diagnosed, two of which were verified by operation; five cases of stenosis, more or less marked; two cases of valvular stenosis; two perforations, one of which was verified by autopsy; one case in which casts of mucosa was expelled; one case from which seven adenomata were removed from the upper rectum; in three cases jaundice was marked; three cases had hemorrhoids and one case had rectal abscess and fistula; one case suffered an impaction in the sigmoid, the size of a fetal head, the result of stenosis below and thinning of the musculosa above; one case had infected gall-bladder which required drainage; in four cases appendiceal involvement was diagnosed; in one case in which appendicostomy was performed, adhesions were found, the result of an attack since the dysentery was established, and in this case great thickening of the peritoneum and a tubercular family history afforded reason for suspecting in this case a tubercular complication. However, Lewis' law could not be verified.

In the treatment, the author first referred to the importance of selecting a proper diet for these cases, and then referred to the use of formalin and boracic acid solution, and formalin and copper phenolsulphonate solution in high irrigations through a recurrent tube which he has devised specially for that purpose. He also referred to treatments through the sigmoidoscope with silver nitrate followed by the installation of borac acid and aristol, or iodoform and bismuth subnitrate and olive oil.

The author concludes that the washing away of necrotic material and debris, as also the infecting agents is an important matter in the treatment of these cases and stated that these stimulate the vaso-motor supply, relieve passive congestion and stasis, increase the amount of fresh blood to the inflamed structures, and perhaps aid in the development of antitoxic bodies.

"SOME RECENT CONTRIBUTIONS TO THE PHYSIOLOGY OF THE RECTUM."

By Dr. Samuel T. Earle, Jr., of Baltimore, Md.,

who sated that the properties of the external sphincter resemble those of plain muscle; that the anus closes by permanent tonus of the two sphincters independent of the will, but is supplemented by it for voluntary control, that the tonus practically disappears after section of the nervi erigentes, providing thereby that the closure depends upon the constant expenditure of nervous energy, and not upon the elasticity of the muscle and the arrangement of its fibres.

That there are constrictor and dilator fibres to the internal sphincter which can be stimulated reflexly through the spinal cord, proving a reflex center in the lower portion of the cord; that through this center, either reflexly or voluntarily, the internal sphincter can be dilated or constricted and the external sphincter can be inhibited.

REPORT OF A CASE. "PLATE WITH FALSE TEETH IN SIGMOID."

By Dr. Samuel T. Earle, Jr., of Baltimore, Md.

Mrs. F. H. D. the latter part of August, 1907, while eating ham, swallowed a plate with two false teeth. Ten days later she had a violent attack of pain in the abdomen, followed by a chill and fever; there was no recurrence of this for one and a half months. Since then they have recurred from time to time, but not as severe, nor have they been attended with chill and fever. A skiagraph taken of the lower abdominal and pelvic regions showed the plate in the sigmoid flexure of the colon, on a level with the promontory of the sacrum. Examination through the sigmoidoscope brought them into view at the point shown by the x-ray. There was considerable tenesmus, and the passage of a good deal of mucous, also a tendency to constipation. Under the influence of two hypodermics of morphine, gr. 1-4, hyoscin hydrobromate gr. 1-100, and cactina which produced satisfactory anaesthesia, Dr. Earle was able to grasp the plate through the sigmoidoscope, with a pair of long alligator forceps, and withdraw it immediately behind the sigmoidoscope.

"GALVANIC ELECTRICITY IN THE TREATMENT OF HEMORRHOIDS, FISSURE, PROLAPSE, ULCERATION AND NON-MALIGNANT STRICTURE OF THE RECTUM."

By Dr. Wm. L. Dickinson, Saginaw, Mich.,

who stated that he did not claim that this is par excellence the treatment for each and every case of hemorrhoids, fissure, prolapse, ulceration and non-malignant stricture of the rectum but that in suitable cases, and also where from fear, physical conditions, or other reasons, the patient refuses to submit to surgical measures, the method had proven its utility.

In the use of galvanism, sight should not be lost of the different properties of the two poles, remembering that we always have physical and therapeutical properties peculiar to each pole, and exactly opposite in effect. The positive pole produces oxygen, is acid, hemostatic, sedative, contracts and hardens tissue, is an acid caustic, and produces hard, firm cicatrices, is also a vaso-constrictor. While the negative pole produces hydrogen, is alkaline, dilates blood-vessels, thus increases bleeding, causes hypersensitiveness, liquifies and disintegrates tissues; being an alkaline caustic, the resulting cicatrices are soft and yielding; it is also a vaso-dilator.

Internal hemorrhoids are successfully treated with the electric needle, as follows: Cocanize the hemorrhoid, then introduce a platmum or common cambric needle into it, attached to the positive pole, while the negative pole is connected with a large abdominal pad. Use a current strength of fifteen mille-amperes for fifteen or twenty minutes, or until the hemorrhoid is rendered hard and unyielding. Best to treat one hemorrhoid at a time.

Anal fissure should be cocanized, then a copper probe attached to the positive pole should be applied until a pronounced deposit of the oxychloride of copper salt is obtained. There will be considerable soreness for a few days, but the patient is always greatly benefited by the first treatment if not cured by it, and is always cured by five or six treatments.

Where the edges of a fissure are greatly hypertrophied the negative pole should be applied to cause liquifaction of the dense tissues.

In cases of prolapse where the redundancy of the rectal wall is of

moderate degree, galvanism is of marked benefit, an electrode attached to the positive pole should be introduced into the rectum and a current of fifteen to twenty-five mille-amperes used daily for ten or fifteen minutes. Stricture of the rectum is successfully treated by the same method as urethral strictures, viz: pass an olive pointed electrode, one or two sizes larger than the caliber of the stricture down to and gently pressing against the stricture, this electrode should be connected with the negative pole, and a current of ten to twenty mille-amperes used, until the tissue is softened and relaxes allowing the instrument to pass. Treatments should be given every five or six days, using a larger bougie each time.

When there are several small ulcers in the rectum, the rectal pouch should be filled with normal saline solution, then introduce a long copper electrode, attached to the positive pole. using a current of twenty-five or thirty mille-amperes, continuing the treatment until the effect of the oxychloride of copper is obtained.

Where the ulcers are large and deep, the better method is to treat each one individually with the zinc-mercuric cataphoresis, using olive pointed electrodes, and a current of twenty to thirty mille-amperes.

"DYSENTERY"

By Dr. J. M. Mathews, Louisville, Ky.,

who reported a case of amoebic dysentery in a man, 45 years of age, who had never been farther south than Louisville, Ky. He had been treated for ten years for a diarrhea which entirely disappeared at times, but in the course of a few months it would reappear. A proctoscopic examination was made and an ulcerated condition of the entire rectum and lower half of sigmoid was observed. A number of the ulcers were curetted and a microscopic examination made. No amoeba were present. Ulcers were all healed and patient well in three and a half months. In about ten months patient returned to the office and was found to be in about the same condition as before. Another scraping was done and a microscopic examination made. Numerous amoeba were present.

Patient being a whole-sale fruit dealer, had handled and eaten raw tropical fruits for more than twenty years. There is no doubt about his infection occurring in this way.

Report of second case. A boy, ten years of age, with a good family history. He had so-called dysentery for two years. Had, of course, been treated for the same during this time. He was thin and aenemic, had temperature every afternoon from 99 to 101. Pulse rate correspondingly increased. Had from five to fifteen actions every day. He was placed in the Hanes (inverted position) and examined with the sigmoidscope. There seemed to be an abrasion of the superficial protective epithelial cells along the lower extremity of the sigmoid and rectum. When a pledget of cotton was rubbed over the mucous surface it would be very slightly stained with blood. No other pathology could be made out.

Patient was put in bed and was not allowed to get up except on the commode. He was given concentrated liquid and semi-solid food. The bowel irrigated every morning with normal saline solution and in the afternoon a local application of argyrol or ichthyol was made.

He remained in the infirmary four weeks, and, at the expiration of which time, he was entirely free from diarrhea, with an increase in weight of twelve pounds. One month later he had gained eight pounds.

While such as these are referred to as cases of dysentery, they are types of diarrhea due to more or less fermentation in the upper bowel, and also, the sensitive condition of the mucous membrane, above referred to, in the lower bowel.

Report of third case. A man 42 years of age, who had an intense diarrhea for three years. It came on in the month July after a day of hard manual labor. Weather was very warm and he had eaten quite freely of fresh vegetables. Attack was sudden and the diarrhea was preceded and accompanied by much abdominal pain Actions from ten to fifteen each day. During his two years illness he would improve under the influence of diet and rest, but did not feel at all well at any time.

When he first came to the office he showed every external evidence of being in the latter stages of malignant disease. We had him assume the inverted posture and the examination at once revealed a dozen or more small ulcers along the upper rectum and lower sigmoid.

He was put in bed and given rich concentrated food. Irrigations and local applications were made to the ulcers every day. He was sent home in five weeks and had gained fifteen pounds and was well.

In this case, as in the case just previously reported, there was no specific cause that could be made out. The disease in both cases yielded easily to treatment. In the first case it was proven to be amoebic dysentery, in the second and third cases they were types of diarrhea, or, so-called dysentery of a non-specific origin, so far as we are now able to determine. I doubt not that in the future many of the more simple forms of intestinal disturbances will be proven to have their specific causes.

Positions for Examination, Treament, etc.—About three years ago Dr. Mathew's partner, Dr. G. S. Hanes, in treating a difficult case, discovered a position that has been employed ever since where the proctoscope is used. The patient is placed in an absolute inverted position, hanging over the edge of a table or chair on the thighs, with one shoulder supported on a chair of sufficient height. The opposite hand is supported upon the floor or two chairs can be used, one for each shoulder, the head passing down between them.

A special table for this position is in course of construction.

When the patient is in this position the entire weight of the abdominal viscera falls upon the diaphragm which pulls upon the sigmoid and rectum and brings them more nearly in the direction of a straight line. Atmospheric pressure completely distends the rectum and lower portion of sigmoid in most cases. A complete view of these parts can be had by the use of a reflected light. The discomfort to the patient of distending the bowel by forcing air into it is never necessary except in high examinations. The surgeon is in a comfortable position, standing by the patient, and looking down into the bowel. An enema can be given easily in this position and you know the solution passes up into the sigmoid and colon. It affords many advantages over other positions.

"THE CHOICE OF AN ANAESTHETIC IN RECTAL SURGERY."

By Dr. Jerome M. Lynch, of New York City,

who stated that before the days of the specialist in anaesthesia, no matter how expert the surgeon, his success was more or less at the mercy of the recent college graduate, or undergraduate, who secured a hos-

pital appointment and came into the operating room as the anaesthetist, without any preliminary study of the art and without any knowledge of the influence of the different anaesthetics upon the human system. Now the day of the specialist has come, and with it the trained anaesthetist, making incalculably happier the surgeon's task.

Nevertheless, the surgeon having studied his patient's system, and understanding his condition as the anaesthetist can not, should use his own judgment in the choice of the anaesthetic to be given.

It is important that some method of shortening the anaesthesia be employed; that the intake of chloroform or ether be lessened by giving the patient some less objectional or less toxic drug, or by some preceding anaesthetic less hazardous.

Morphine and hyosciene, either as a substitute or preliminary to general anaesthesia, have been used successfully in some seventy-five cases. At the New York Polyclinic, St. Bartholomew's and in private practice, considerable experience has been had with ethyl chloride, and it has been used in over six hundred cases, as a general anaesthesia for short operations and examinations, or as preliminary anaesthetic to chloroform or ether, without a single accident or bad result.

The author was the first to advocate the drop method in the use of ethyl chloride. He found that by this method the drug could be used more intelligently and that much less of the anaesthetic was required. Another advantage in this procedure is that it does not crystallize all over the mask as it does in spray method.

The author did not advocate this anaesthetic to the exclusion of ether or chloroform; but held that for examinations, short operations, as a preliminary to ether or chloroform, and as an adjuvant to hyoscine and morphine, it is safer and more efficacious than any anaesthetic we use today. He was decidedly opposed to any form of closed inhaler. To the open method must be attributed the good results with ethyl chloride. He did not find ethyl chloride, however, suitable for any anaesthesia which lasts over ten minutes, as vomiting is apt to follow a prolonged use of this drug. It is also contra-indicated in alcoholics, children with adenoids, patients suffering from acutely inflamed conditions of the throat, or advanced cardiac disease. Spasm of the larynx has occurred in some 50 per cent. of the cases; but this is at

once relieved by withdrawing the anaesthetic, or by substituting a few drops of chloroform.

Another anaesthetic that has been overlooked, and one that is particularly safe, is nitrous oxide, alone, or with oxygen.

In the author's opinion, the surgeon would get better results, and the anaesthetist gain confidence, if the anaesthetic were not rushed in the beginning. The anaesthetist should take plenty of time; let the patient get used to the smell of the anaesthetic and accommodate himself to his surroundings. The patient, then, is not frightened, it takes less of the anaesthetic, and he comes out of it in better condition. Under no circumstances should a patient be too forcibly restrained in the early stages of anaesthesia.

In conclusion, the author stated be sure of your anaesthetist. No man should give an anaesthetic alone, till he has been proved competent.

Above all, an anaesthetist is required who is competent in an emergency. The man who knows what to do when things go wrong, and does it, is the man who is worth his fee. There is no time for cogitation when a man's heart stops beating. But there is hope for the patient and success for the surgeon *if the man behind the dope is on his job.*

"SURGERY OF SPECIFIC DISEASES OF THE RECTUM."

By Dr. Geo. B. Evans, Dayton, Ohio,

who said that venereal diseases of the rectum constitute maladies which have neither been mastered by the syphilographer nor the proctologist. The former is not familiar with the armamentarium for rectal exploration, and the latter is not thoroughly familiar with venereal diseases. The manifestations of syphilis escape the former because they are often removed from the field of vision; while the attention of the latter is called to the fact because pain exists in the rectum. In the first place, two propositions confront us: First, is this form of stricture of the rectum a local manifestation; that is, is it due to a primary sore? Second, is it the result of secondary or tertiary syphilis? According to an able author it is due to the rectum becoming inoculated through the secretions from the sores upon the vulva, thus giving rise to chancroidal ulcers, these ulcers becoming cicatrized and con-

striction taking place. Again, the presence of chancroids at the orifice of the vagina or about the anus gives rise to an inflammation of the areolar tissue surrounding the lower portion of the gut, and by the effusion of inflammatory material at certain points, gives rise to constriction either in this way alone, or by directly producing inflammation and ulceration of the mucous coat of the bowel. Personally, the author had seeen many cases of chancroid of the vulva of the worst kind—extending down and involving the anus; being filthy in the extreme, but stricture of the rectum did not exist. If chancroidal virus was carried into the rectum, we would find that nearly every prostitute would have a stricture of the rectum. Secondary induration of the rectum, following a chancroid of the anus, the author believed could occur; this induration being followed by chronic inflammation and ulceration, and finally, developing cicatricial tissue, forming an extensive stricture. Again, this stricture may be the result of true tertiary inflammation or ulceration, the rectal wall being infiltrated with a syphilitic neoplasm, or by becoming organized into contractile tissue. produce the stricture. The true explanation of the preponderance of stricture in women, whether specific or otherwise, is to be sought for rather in the anatomical relations of the rectum, than in any constitutional diathesis. The site of the stricture is generally at or about the attachment of the fibres of the levator ani muscles; this possibly plays an important causative factor indirectly, there being more or less constriction, consequently if there is any ulceration here the power of resistance in the patient is not sufficient to overcome the trauma. Here it is where the faeces meet their first resistance; here it is where these strictures undergo contraction and chronic inflammation follows. If one believes that all strictures, not cancerous, are syphilitic, they may use antisyphilitic remedies, but they will generally find that they fail to produce the desired results.

Finally, the following conclusions were formulated: That rectal stricture may follow chancroidal infection by virtue of its pathology, which may be the result of absorption or lodgment of infectious matter on mucous membrane or in submucous or even perirectal tissue, and that rectal strictures may be but a latent manifestation of syphilitic infection. That this belief is in accord with the author's experience

and is the reasonable deduction from the experience of other competent observers. Moreover, that while iodides are usually prescribed in these conditions, they are not of curative value, and that it is only by incision and internal mechanical dilatation that these strictures of specific nature can be made tolerable.

"SIX CASES OF PROFOUND SECONDARY ANAEMIA DUE TO BLEEDING INTERNAL HEMORRHOIDS; AND ONE CASE OF NECROSIS OF THE RECTUM AS A RESULT OF SELF-TREATMENT,"

were reported by Dr. Dwight H. Murray of Syracuse New York, who held that the profession was not entirely blameless for the serious results which occurred in this class of cases, because it is looked upon by the laity as a matter of no serious moment, and in many cases the physician does not insist upon a thorough examination and prompt treatment.

The first case reported was one of bleeding hemorrhoids, secondary anaemia, delirium, amnesic aphasia and other critical symptoms. A good recovery was the result of the operation.

The second case was one of hemorrhoids and a villous polypus resulting in profound anaemia, heart weakness and a general appearance resembling that of malignant disease. This case made a full recovery following operation.

The third, fourth and fifth cases resulted in profound anaemia, weakness, melancholia, and invalidism, all making a good recovery after an operation.

The sixth case had been long neglected and died as a result of the profound anaemia two days after he was first seen by the author and before the patient consented to an operation. The examination showed: haemoglobin ten per cent and red blood corpuscles 1,000,000.

The author held that in case of bleeding internal hemorrhoids patients may lose more in ten minutes than can be recovered in as many days, and that surgeons were not justified in delaying an operation, also that it would be far better for the physician in charge to withdraw from the case, if such a patient refuses to follow his advice when he believes that an operation is necessary.

The author believed that the primary cause in many cases of secondary anaemia can be found, if sought, in the last three feet of the intestinal canal.

The cases of necrosis of the rectum was caused by the injection of two-thirds of a teaspoonful of headlight oil, upon retiring every night, over a period of several weeks. The treatment was recommended to him by a fellow employee. The case made a good recovery and at this time, five years after the operation, no stricture of the rectum has resulted.

EXHIBITION OF A NEW EXAMINING SPECULUM.

By Dr. Dwight H. Murray, Syracuse, N. Y.,

who states that it has been said "of the making of many books there is no end" and so it seems to be with instruments.

Among the good qualities of an examining speculum there should be:

1. It can be introduced with little discomfort to the patient.
2. It must allow a good view of the part to be examined.
3. It can be withdrawn without added discomfort.
4. It can be easily cleaned and sterilized.

He has found that this speculum possesses these qualities in a goodly degree, and he takes pleasure in presenting it to the society, hoping that some may find benefit in its use.

"SPONTANEOUS INTESTINAL ANASTOMOSIS."

By Dr. James P. Tuttle, New York City,

whose paper consisted in a discussion of the means by which nature overcomes intestinal obstructions through spontaneous anastomosis. Four cases were reported in which the obstruction suddenly gave way, and the patients lived for various periods, with more or less regular movements of the bowels. These movements were afterward shown in one case by autopsy, and in two cases by operative interference, to have taken place by spontaneous lateral anastomosis between different portions of the bowel. The fourth case was never operated upon but being at the point of death, with great abdominal distention and inflammation, was relieved by some sort of giving away of the obstruction and eventually recovered. This patient had suffered from colitis and

fecal stasis high up for a long time; since this experience, however, these symptoms have disappeared and she has remained entirely well.

"MESOSIGMOIDOPEXY, WITH REPORT OF TWO CASES" was the title of a paper by Dr. Louis J. Hirschman, Detriot, Mich.

After defining the different forms of prolapse of the rectum, the author called attention to the unsatisfactory results so far attained in the various suspension operations for prolapse of the third degree. He argued that as in operations on the retroverted uterus, the shortening of the natural supports of the womb has superseded the illogical attachment to the anterior abdominal wall. He hoped that the messentery, the natural support of the bowel, will be used to replace the old fixation methods used heretofore.

He reported two cases suffering from prolapse of the rectum sigmoid of the third degree, both of whom had had other operative measures performed without satisfactory results. These two cases were operated on with entire relief by the author's method of mesosigmoidopexy—the technique of which is as follows:

Under hyoscine, and morphine anesthesia, fortified with a small quantity of chloroform, the abdomen was opened a little to the left of the median line, the incision paralleling Poupart's ligament. Nearly one-half of the sigmoid flexure was found telescoped into the rectum, and the space formerly occupied by the uterus filled with the rest of the prolapsed sigmoid. The stump of the right broad ligament was found firmly attached to the sigmoid, thus holding the lower part of it in the prolapsed condition. The mesentery of the sigmoid was very much elongated, allowing the bowel to remain in the lower pelvis. The adhesion to the stumps of the ligament was separated, and the stump of the broad ligament covered over the peritoneum, the prolapsed bowel lifted out of the pelvis, and the outer surfaces of the mesentery of the large loop of the sigmoid lightly scarified. Beginning toward its deep attachment (about six inches from the bowel in this case) the two opposing surfaces of the meso-sigmoid were brought together by interrupted 20 day catgut sutures (No. 2). Three rows about an inch apart were placed in this manner, the upper row being three inches from the bowel. As the sutures were tied the sigmoid and the rectum were lifted from their prolapsed position.

For fear that the curve of the loop might be lessened and possible kinking take place (a rather remote possibility on account of the strength of the adhesions), the longitudinal muscular band of the sigmoid, together with an eighth of an inch of the serous and muscular coats of the bowel on either side of the band, was rolled in upon itself by transverse interrupted catgut sutures, placed three quarter inches apart around the curve, and for two inches beyond at each side. This rolling in of the muscular band made a rib of firm muscular tissue which materially increased the size of the curve, and greatly strengthened it.

The scarification of the sutured surfaces of the meso-sigmoid assured us of an adhesive surface of over 18 square inches, and yet allowed perfect motility of the organ. The abdomen was closed, the rectocele reduced and repaired, and the prolapsed anal mucous membrane resected.

In the after-care of these cases the patient is kept confined in bed on a restricted assimilable fluid diet and the bowels not allowed to move for about ten days. At the end of that time the diet is gradually increased, but the patient not allowed to get out of bed and walk until the end of the fourth week.

In the two cases reported by the author in his paper, reports from the patients six and eighteen months afterwards respectively, evidenced the fact that they were in perfect health and both having natural normal bowel movements without assistance.

While these patients were women, the same condition occurs in men and the same technique is applicable to them.

"CARCINOMA OF THE RECTUM; COMPARATIVE RESULTS WITH REPORT OF TWO CASES."

By Dr. J. R. Pennington, Chicago, Ill.,

who states that the purpose of this brief paper was not so much to call attention to any particular scientific manner of treating a case of circinoma of the rectum as it was to report, compare and contrast the result of two cases which, in the beginning, were very similar. One patient, however, followed the advice of a Christian Science healer, and the other that of her physician.

To epitomize: The first patient was a male 48 years of age and apparently healthy, robust and vigorous.

The second one was a female 69 years of age, weak, emaciated, and hardly able to withstand a surgical operation.

The man dictated what should and should not be done for his condition.

The woman said, "Doctor, I am in your hands and trust everything to you. Do the very best you can for me and I will be satisfied."

He pinned his faith to Christian Science.

She pinned her's to her doctor.

He spent the last year of his life in a most miserable and wretched condition—a condition appalling and pitiful to behold.

She has suffered no inconveniences from the operation and has spent the past year of her life enjoying the very best of health, happiness and pleasure.

"PRIMARY MELANOTIC SARCOMA OF THE RECTUM AND ANUS WITH REPORT OF TWO CASES."

Louis J. Krouse read a paper on the above subject and stated that very little space or none at all has been devoted to this subject in works on general surgery. He quotes what the various authors on diseases of the rectum say in reference to this class of new formations. He has gathered all the cases of this disease which has been reported in the literature up to date, and has compared the relative infrequency of this class of neoplasm with other malignant growths located in the same region. Of the 19 members of the American Proctologic Association with whom he corresponded only four reported six cases, which added to the two of the author's cases make eight cases showing the infrequency of this class of new formation. Fifty-two cases were collected from the medical literature, making altogether sixty cases.

In forty-five cases, in which the age and sex of the patients were specified, there were twenty-eight males and only seventeen females. No decade was exempt except the first—the youngest, being a boy, aged seventeen; and, the oldest, a man, aged seventy-five. That it was more prevalent in the sixth decade, being disease of the middle period of life and old age. The average age being forty-nine and five months.

Of the fifty-one cases in which the location of the growth was noted, thirty-seven were situated in the anus, thirteen in the rectum and one in the sigmoid. The anal representing 72.5 per cent., the rectal 25.5 per cent.

Concerning the etiology of these melanotic growths, some authors claim that in the great majority of cases, one can find a distinct positive cause. It is the opinion of these authorities that the growths originate from birth marks of pigmented moles and warts. Wagner found it to be the case thirty-seven times in the one hundred and forty-five cases of dieterich or 26.2 per cent. In his own cases the percentage was higher. being found nine times in the nineteen cases of 47.3 per cent. Eve found it to occur twenty-six times in the thirty-three cases of melanotic sarcoma or 78.8 per cent. As pigmented moles or warts are not likely to be found in the rectum, the author suggests that perhaps the papillae, which are situated at the border line where the skin and mucous membrane unite, may act as the starting point from which these growths originate.

From the author's compiled table he finds that thirty-one cases were operated upon and ten were not. Of the thirty-one cases only twenty-eight cases can be utilized. Of these eleven had had no recurrences and seventeen had recurrences. Of these five lived beyond the three years limit without recurrences. Tuttle, Key and Drenkhohn each had one case and Esmarck had two. Tuttle's died in three years and four months of metastasis; Key's died at the end of the third year of recurrence; Drenkhohn died of illeus at the end of the third year. Only Esmarck's cases had no recurrences, one was alive at the end of the eleventh year and the other at the end of the third year.

Attention is drawn to the rapid recurrence after operation. Three had recurrence as early as the fourteenth day. Two between the second and fifth month. Four between the fifth and twelfth month and two between the first and third year.

The average length of time that the patient lived after an operation and dying from recurrence was nine months. The shortest was five weeks and the longest was three years.

The duration of the disease was noted in twenty-four cases from the time of the first appearance of the trouble to the day of operation.

The longest was four years and the shortest two months, the average fourteen months and twenty-two days.

The length of time that the patient lived without operative interference can be arrived at from the report of four cases. One lived two years; another one year and five weeks; another one year; and the fourth lived five months; an average of about thirteen months.

Cases operated upon and dying from recurrences, the length of time varied, one died in sixteen days; four died in one to two months; four died in two to five months; three died in one to two years; three died in three to three and half years.

The length of time from the first appearance of the trouble, till death where no operation was performed, only three cases can be utilized: One lived one year and five weeks, one lived two years and eight days and the third lived five months.

A microscopical examination of the tumors revealed that most of them were of the alveolar type.

He concludes his paper with the suggestion that as the course of the disease is so malignant, extirpation is the only rational thing to be done. Not only should the neoplasm be removed thoroughly, but a good deal of healthy tissue should be sacrificed. Should the tumor be located at or near the anus, the sphincters as well as the ingunial gland should be extirpated.

"SOME COLONIC, SIGMOIDAL AND RECTAL CONDITIONS."

By Dr. Edwin A. Hamilton, Columbus. Ohio,

who stated that the ascending and a portion of tranverse colon have to do with absorption of the fluids of the digestive tube. The descending colon and sigmoid are concerned with storing fecal debris. There are changes in the intestinal wall of the descending colon, sigmoid and rectum which are due to the function of these parts. On account of the stagnation fermentation and putrefaction in the contained mass, toxins and bacteria, under conditions favorable to this process, pass through the mucosa into the wall of the bowel. The result of this permeation of the wall of the intestine is an irritation which brings on a round cell infiltration of its layers. This infiltration diminishes the elasticity of the viscus and by its slow but inevitable contraction diminishes its

lumen. This same process of round cell infiltration may attack the mesenteris of these various divisions of the bowel and cause thickening and contraction of them. The main symptoms of this condition is prolonged and intractable constipation with all its morbid sequellae.

After fibrosis has occurred the affected area may be palpated, if the abdominal walls are relaxed. It is needless to remark that all accessible viscera must be investigated and every other cause of the constipated state must be eliminated. Treatment comes under the hygienic, in which diet and colonic lavage occupies a very prominent position.

Surgery must be invoked in the advanced cases when the fibrosis is marked. Any part or all of the colon except the part concerned in the absorption of fluids may be removed. Metchinkoff is a prominent advocate of the idea that the colon is the territory from which most of the poisons which destroy the body originate and that if man possessed no storehouse in which digestion debris may stagnate and putrefy he would be a much more physically perfect animal. So that we may not hesitate to remove any portion of the large bowel no matter how extensive that portion may be, when it has already lost what little functional value it originally possessed.

"RECTAL DISEASES"—A REPORT OF THREE CASES: "CONDYLOMA, LIPOMA AND FOREIGN BODY"

was the title of a paper read by Dr. Lewis H. Adler, Jr., who stated in reference to condyloma that two varieties were recognized—one being of syphilitic origin, called condyloma latum; and, the other condyloma acuminatum, due to irritating discharges of a non-specific source, such as gonorrhoea, leuchorrhoea, and chancroid. The latter form was the variety concerned in the case reported: the patient evidently acquiring the trouble in the practice of sodomy.

The essential peculiarity of the case under consideration being that the numerous cauliflower growths encircling the anus (some being large and others small), was the fact that not only had the growths involved the cutaneous surface but also that they existed within the bowel upon the mucous membrane. The latter, it is true, were quite minute and might have been overlooked by a superficial examination All of the excrescences, even the smallest were pedunculated.

The treatment consisted in the removal of the larger growths by scissors and cauterizing their bases with a paquelin cautery. The smaller growths were destroyed simply by the application of the cautery point. To prevent pain due to the cauterization, the parts were sprinkled liberally with bicarbonate of soda—as recommended by Dr. Jas. P. Tuttle.

The patient made an uneventful recovery.

Case 2. The case of lipoma was not exceptional except for the fact of its occurrence in the ischio-rectal fossa and that it could be pressed backward and forward through a ring of firm tissue, which ring could be distinctly felt surrounding the tumor and through which it glided back and forth very much as a herniaachs.

The growth was removed under ether anaesthesia and was found to extend well up in the ischio-rectal fossa on the right side. The redundant skin was excised and the wound brought together with silkworm gut sutures.

The recovery was uneventful.

Case 3. A very remarkable instance of a foreign body in the rectum was that of a woman forty-two, who had consulted Dr. J. J. McLaughlin of Philadelphia, and then through the doctor, the writer of the paper.

She had reason, about six years previous to seeing Dr. Laughlin, to think she was pregnant, having most of the symptoms pertaining thereto—suppression of menses, enlarged abdomen, morning nausea, etc. For about six months she did not menstruate. At no time did she experience foetal movements. About six months from the cessation of menstruation, the flow returned and she again became regular in this respect. The physician, she was then seeing, informed her that he thought she had had a false conception. Two years later she went south and contracted a diarrhoea, which kept her under the care of physicians, almost constantly, but without experiencing any permanent relief. Six months prior to seeing the author of the paper she had experienced considerable tenesmus within the rectum—the pain being confined to no one point, but was experienced low down in the pelvis and about the rectum. Sometimes a dozen paroxysms would occur in a day. The diarrhoea still continued, many movements occurring in the twenty-four hours.

At no time was there any bleeding from the bowel, and she was not affected with any protrusion, such as piles, etc. About two months be-

fore she saw the author of the paper she passed from the rectum what she termed "a bunch of bones," and a month later a piece of skull.

Upon consulting Dr. McLaughlin, the patient was carefully examined by him and a diagnosis made, which was subsequently confirmed by the author.

At the time of the examination the patient showed marked evidence of being poorly nourished weighing but about seventy-five pounds, her usual weight prior to this trouble being over a hundred. Digital exploration of the rectum revealed a mass situated about four inches up the bowel anteriorly which felt much like the united halves of an open clam-shell, the pieces being sharp and exposed. Extreme care had to be used to avoid cutting or injury to the examining finger. The tissues in which the mass was embedded were greatly hypertropried. A few small pieces of bone were removed at this time. but is was soon evident that the larger mass could not be extracted except under general anaesthesia.

The patient, therefore was admitted into the Polyclinic Hospital and under ether, the sphincter was dilated and the mass of bones removed which proved to be in large part, frontal bones. It was only by the exercise of the utmost care and skillful manipulation of the fingers that some of the larger pieces were removed without injury to the patient or surgeon.

The after treatment consisted in cleaning the parts thoroughly, several times a day, with a two per cent. creoline solution.

The patient made an uneventful recovery and in six months gained about twenty-five pounds and since the operation has had no diarrhoea.

The cause of the condition was uncertain. Two causes naturally presented themselves—a dermoid cyst or the product of an extra-uterine foetation. As the essential symptoms of the dermoid cyst were not present, and, in view of the previous history, the opinion was expressed by the writer that her condition was probably due to the latter cause.

In chronic diffuse interstitial nephritis the patient is generally anemic, and iron will agree with but few. Indeed, in many cases the nervous symptoms are aggravated by its use. Here is where Hagee's cordial of the extract of cod liver oil compound is indicated. It should be given in tablespoonful doses four times a day.—*Am. Jour. Dermatology.*

THE DIAGNOSTIC IMPORTANCE OF THE INDICAN TEST.

That the profession is, each day, becoming more fully awake to the diagnostic and otiologic importance of Indicanuria, is evidenced by the increasing frequency with which this subject is considered in society discussions and medical journal articles. It is now generally acknowledged by all competent authorities that the presence of any considerable proportion of Indican (indoxyl-potassium sulphate) in the urine is definitely indicative of the undue putrefaction of proteid material in the intestinal canal and the constitutional absorption of the toxic products of such putrefaction. The average physician, however, does not seem to realize that the test for indican is not necessarily a laboratory procedure, but that, with but little time and trouble, he can readily determine the presence or comparative absence of indican in the urine and thus often quickly demonstrate whether or not the patient is suffering from intestinal auto-intoxication or auto-toxemia. As a guide to the physician in the making of this simple but important test, there is nothing more helpful than the Indican Color Scale, issued by F. H. Strong Company, makers of Chologestin, which is accompanied with a full interpretation of the several color reactions and a description of what is considered, by many authorities, as the most approved test. A request to the above named firm, 58 Warren St., New York, referring to this journal, will bring one of the Color Scale referred to, together with samples of Chologestin for trial in the treatment of patients requiring combined cholagogue, digestive and antiseptic medication.

For ureteral calculus there are two kinds of treatment, viz: (1) "Visceral drainage." i. e., administer to the patient 8 ounces of fluid every two hours 8 times daily (64 ounces daily). The increased volume of water and consequent exaggerated ureteral peristalsis may float the calculus into the bladder. Within a year I diagnosed and secured three ureteral calculi by means of visceral drainage. One may aid visceral drainage by massaging the kidneys and ureter. (2) The treatment of ureteral calculus is by surgical procedures.—*Byron Robinson.*

Fixation of the uterus by a surgical intervention is only substituting one pathologic condition for another.—*Dr. Lucy Waite.*

Editorial.

W. H. BELL, M. D., Editor.

The Journal will be mailed on or about the 15th of the Month. Subscribers failing to receive it promptly will please notify us at once

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Other Delegates Appointed by the Governor to the International Congress on Tuberculosis.

In addition to the list of delegates to the International Congress on Tuberculosis appointed by President Wyman of the State Medical Association and published in the last number of the Journal, Governor Comer has also appointed a number of delegates. The appointment of these lists should insure a good representation from Alabama at the Congress for the entire time of the meeting.

As previously announced the Congress will continue for three weeks, from September 21 to Ocotber 12. The section meetings will take place the week beginning September 28. The program for the week includes two plenary sessions, one on Monday, September 28, at which it is hoped that President Roosevelt will preside, and the other on October 3. Each of the seven sections into which the Congress is divided will hold two sessions daily, except on the days on which the plenary sessions will take place,

In connection with the Congress a series of lectures is to be given in Washington, and in other cities by distinguished foreigners.

The following are the delegates appointed by the Governor: Dr. W. H. Sanders, Montgomery; Dr. B. L. Wyman, Birmingham; Dr. Glenn Andrews, Montgomery; Dr. W. W. Dinsmore, Decatur; Mrs. R. A. Lee, Greenville; Hon. H. P. Reese, Selma, and Mr. D. H. Marbury, Marbury.

The Southern Medical Association.

The next annual meeting of the Southern Medical Association will be held in Atlanta, Ga., November 10, 11 and 12, 1908. Everything indicates now that this will be a splendid meeting. A large attendance is expected. The programs for the different sections are being arranged, and a large number of interesting and instructive papers have already been promised. We urge any of our readers who are expecting to present papers to notify either the chairman or secretary of the section in which his paper will be read at once of the title, so that it may be sure to find a place on the program. The Chairman for the Section on Medicine is Dr. Seale Harris, Mobile, Ala., and the Secretary is Dr. H. E. Mitchel, Birmingham, Ala. The Chairman for the Section on Surgery is Dr. W. F. Westmoreland, Atlanta, Ga., and the Secretary is Dr. J. L. Crook, Jackson, Tenn. The Chairman for the Section on Ophtholmology is Dr. J. T. Herron, Jackson, Tenn., and Secretary is Dr. A. B. Harris, Birmingham, Ala.

Part of section one of the constitution says:

"We recognize that a greater opportunity for self-advancement and achievement in the realm of scientific research is required by the progressive and cultured physicians of this district than is afforded by the States' societies, and which, on account of its large membership, is denied them in the American Medical Association. We believe that the profession as a whole will be benefited by such a society, and assuredly that the members of this organization will have excellent opportunities to develop their talents.

"We believe that such an association will be a long stride forward in perfecting the plan of organization which has been so splendidly promoted by the American Medical Association, and will bring all the mem-

bers in the district into closer touch and more perfect harmony with each other and the National Association."

All who are in accord with these purposes of the association, if not already a member, should at once make application for membership, and attend the Atlanta meeting. Dr. B. L. Wyman, Birmingham, Ala., President, or Dr. Oscar Dowling, Secretary-Treasurer, Shreveport, La., would be glad to hear from all who desire to become members.

We are just in receipts of a letter from Dr. Dowling announcing the fact that the railroads have granted excursion rates, one and one-third fare plus 25 cents, from all points embraced in the territory covered by this association. Tickets will be on sale November 7, 8 and 9, good until November 14, leaving Atlanta with three days transit limit returning. The published rates for the round trip from Birmingham is $6.85; Montgomery, $7.25; Mobile, $14.45; Opelika, $4.45.

Meeting of the Birmingham Medical Library Association.

A delightful meeting of the Birmingham Medical Library Association was held at the home of the president, Dr. W. G. Harrison, 1226 Iroquois Street, on the evening of September 8.

Interesting reports of cases were made by Dr. U. J. W. Peters and Dr. E. M. Prince, and discussions were indulged in by several other members. But the most pleasant part of the meeting was at the conclusion of the scientific program, when the charming wife of the host appeared, and, assisted by Miss Bowie, served delightful refreshments. After this an hour spent in social converse passed only too quickly.

This will be remember by the members as one of the most enjoyable of the meetings of the association.

Dr. W. R. Bishop.

Dr. W. R. Bishop was born in Talladega, Ala., Feb. 4, 1873, and died in the same city on Aug. 4, 1908. In his death the profession has lost a brilliant and valuable member. He was educated in the public schools of Talladega and the Alabama Polytechnic Institute at Auburn, from which latter institution he was graduated in 1893. In 1895 he graduated from the medical department of the Tulane Universi-

ty of New Orleans, La. He took post-graduate courses in New York in 1896 and 1900. He was a loyal member of the Talladega County Medical Society, of which he had served both as secretary and president. He was also a member of the State and American Medical Associations.

The Mississippi Valley Medical Association.

We are in receipt of the preliminary program of the thirty-fourth annual meeting of the Mississippi Valley Medical Association which meets at the Seelbach Hotel, Louisville, Ky., Oct. 13, 14, 15, 1908.

The entertainment projected by the local profession will include a smoker in the Rathskeller of the Seelbach, the finest of its kind in this country; a musicale and reception on the evening of the second day, to the members and ladies; a luncheon to the visiting ladies at the beautiful Country Club.

The officers are: Arthur R. Elliott, President, Chicago, Ill.; F. F. Lawrence, First Vice-president, Columbus, Ohio; R. C. McChord, Second Vice-president, Lebanon, Ky.; Henry Enos Tuley, Secretary, Louisville, Ky.; S. C. Stanton, Treasurer, Chicago, Ill.

The following addresses will be delivered:

Address of Welcome on Behalf of the State—Hon. A. E. Willson, Governor.

Address of Welcome on Behalf of the City—Hon. Jas. F. Grinstead, Mayor.

Address on Behalf of the Local Profession—Dr. L. S. McMurtry.

Address in Medicine—Dr. George Dock, Ann Arbor, Mich. Tropical Disease in the Mississippi Valley.

Address in Surgery—Dr. Arthur Dean Bevan, Chicago, Ill. The Surgery of the Kidney.

PRELIMINARY PROGRAM.

M. A. Austin, Anderson, Indiana—Syphilitic Crises, Stimulating Surgical Emergencies.

Fred A. Besley, Chicago, Illinois—Rectal Anesthesia.

J. E. Cannaday, Charleston, West Virginia—Surgical Treatment of Exophthalmic Goitre.

Alfred C. Croftan, Chicago, Illinois—Pancreatis Diabetes and Its Relation to Gall Stones.

W. D. Haggard, Nashville, Tennessee—Etiology and Pathogenesis of Pancreatitis.

Forrest E. Haydon, Nashville, Tennessee—Neurasthenia.

M. L. Heidingsfeld and C. A. Ihle, Cincinnati Ohio—Carbon Dioxide Snow in the Removal of Naevi, Port Wine Stains, Tattoo Marks and other Forms of Demiteses, demonstrated from 25 colored lantern slides.

Allen B. Kanavel Chicago, Illinois—Infections of the Hand.

Wm. J. Mayo, Rochester, Minnesota—Surgical Treatment of Pancreatitis.

Hugo Ad Oldenborg, Chicago, Illinois—Points in the Treatment of Traumatic Joint Affections by Massage.

M. Milton Portis, Chicago, Illinois—Hyperchylorhydria and Its Treatment Based on Animal Experimentation.

H. J. Scherck, St. Louis, Missouri—Fever Resembling the Afternoon Temperature of Phthisis, Due to Syphilis of Long Standing.

J. Henry Schroeder, Cincinnati, Ohio—Physiology and Chemical Pathology of the Pancreas in Pancreatitis.

J. A. Stucky, Lexington, Kentucky—Some Object Lessons in Otology for the General Practitioner.

H. O. Walker, Detriot, Michigan—Tumors of the Mediastinum. with a Report of a Successful Operation.

Channing W. Barrett, Chicago, Illinois—Recognition and Treatment of Ectopic Gestation.

Carl D. Camp, Ann Arbor, Michigan—Allochiria, with a Report of Two Observations.

Leo M. Crafts, Minneapolis, Minnesota—Expert Testimony and the Medical Witness.

T. D. Crothers, Hartford, Connecticut—A New Field of Practice in Spirit and Drug Neuroses.

Geo. B. Evans, Dayton, Ohio—Surgery of Venereal Stricture of the Rectum.

Paul Gronnerud, Chicago, Illinois—Anatomical Landmarks of Abdominal Surgery in the Cadaver.

Earl Harlan, Cincinnati. Ohio—Resume of the Various Methods of Technique for Dislocated Kidney, and the Application of Each.

Herman Hoppe, Cincinnati, Ohio—Cerebral Rheumatism.

G. F. Lydston, Chicago, Illinois—Bladder Tumors.

Franklin H. Martin, Chicago, Illinois—Observations on Splanchnoptosis.

W. W. Pennell, Mt. Vernon, Ohio—A Case of Human Rabies.

E. S. Pettyjohn, Topeka, Kansas—Effects of Nervous Diseases on the Expectancy and the Risk of Life Insurance.

B. Merrill Ricketts, Cincinnati, Ohio—Protracted Birth of Second Intra-Uterine Twin (a resume) Biologically Considered.

Nathan Rosewater, Cleveland, Ohio—Diagnosis of Gastric and Gall Stone Pains.

Hugh T. Patrick, Chicago, Illinois—Remarks on Tic and Chorea.

S. C. Carson, Greensboro, Alabama—Ante-Partum Hour-Glass Contraction of the Uterus.

J. H. Stealy, Freeport, Illinois—Fracture of Astragalus, with Dislocations of the Fragments.

Geo. F. Suker, Chicago, Illinois—Early Treatment of Spuint.

F. Gerney Stubbs, Chicago, Illinois—Systemic Effects of Chronic Infections of the Throat and Nose.

B. F. Turner, Memphis, Tennessee—Hysterical Manifestations Following Traumatisms.

Alex C. Weiner, Chicago, Illinois—New Features in the Treatment of Tuberculosis of the Spine.

Ferd C. Valentine, New York City—The Indications for and Technique of Internal Urethrotomy.

Robert H. Babcock, Chicago, Illinois—A Case of Mediastinal Sarcoma, with Special Reference to Diagnosis.

A. H. Cordier, Kansas City, Missouri—Mixed Tumors of the Parotid Gland.

David L. Edsall, Philadelphia, Pennsylvania—The Present Status of Organotherapy.

Daniel N. Eisendrath, Chicago, Illinois—Pyleonephritis: Its Clinical Forms and Treatment.

D'Orsay Hecht, Chicago, Illinois—Newer Methods in the Treatment of Sciatica and Other Neuralgias; A Clinic Report.

John H. Hoolister, Chicago, Illinois—Conclusions from the Clinical Standpoint of the Value of Opsonic Therapy in Surgical Infections.

Sidney Langes, Cincinnati, Ohio—The Roentgen Diagnosis of Stricture of the Esophagus.

Frank P. Norbury, Jacksonville, Illinois—The Blood and Blood Pressure in Border-Line Mental Disorders.

F. M. Pottenger, Monrovia, California—The Causes of Our Failure in the Treatment of Tuberculosis.

C. A. Vosburg. Saint Louis, Missouri—Malignant Disease of the Cervix Uteri.

L. H. Warner, Brooklyn, New York—The Use and Abuse of Basterial Vaccines in Medical and Surgical Practice.

Ralph W. Webster, Chicago, Illinois—The Use and Abuse of the Clinical Laboratory.

Chas. T. Souther, Cincinnati, Ohio—Obstruction of the Bowel.

W. D. Haines, Cincinnati, Ohio—Gastric Ulcer, with Special Reference to Its Pre-Cancerous Influence.

J. H. Landis, Cincinnati, Ohio—Feeding and the Use of Alcohol in Typhoid Fever.

J A. Lichty, Pittsburgh, Pennsylvania—The Incidence of Gall Bladder Trouble and Gastric Ulcer.

J. Rawson Pennington, Chicago, Illinois—Bismuth Paste in the Treatment of Rectal Fistula.

S. G. Bonney, Denver. Colorado—Climate and Tuberculosis.

E. W. Saunders, Saint Louis, Missouri—Causation and Treatment of Infantile Convulsions.

Walter L. Bierring, Iowa City, Iowa—Multiple Serositis.

M. H. Mack, Chicago, Illinois—Observations on the Liver in Five Hundred Cases of Gastro-Intestinal Diseases.

Albert J. Ochsner, Chicago, Illinois—Diagnosis of Pancreatitis.

Joseph A. Blake, New York City—The Combined Operation for Carcinoma of the Rectum.

Sanger Brown, Chicago, Illinois—Treatment of Acute Insanity.

Joseph L. Miller, Chicago, Illinois—Some Factors in the Development of Pulmonary Edema.

G. I. Hogue, Milwaukee Wisconsin—Improved Methods for Preparation of Gycerine Jelly for Microscopic Specimens.

David I. Wolfstein, Cincinnati, Ohio—Reflexes.

M. M. Smith, Dallas, Texas—Practical Suggestions in Reference to the Successful Management of Tuberculosis.

Earl M. Gilliam, Columbus, Ohio—Enterostomy—Its Value in Intestinal Obstructions.

Papers (titles not yet sent in) from the following:

Henry Sewell, Denver, Colorado.

A. E. Halstead, Chicago, Illinois.

Robert B. Preble, Chicago, Illinois.

Charles E. Paddock, Chicago, Illinois.

Frank X. Walls, Chicago. Illinois.

Norval H. Pierce, Chicago, Illinois.

Wm. B. Coley, New York City.

Frank A. Jones, Memphis, Tenn.

J. H. Carstens, Detriot, Michigan.

Albert E. Sterne, Indianapolis, Indiana.

George C. Bloodgood, Baltimore, Maryland.

The members of the Mississippi Valley Medical Association, in attendance on the Louisville meeting, have been cordially invited by the management of the French Lick Hotel Company, French Lick, Ind., to stop over on Monday, October 12th, as guests of the hotel management.

Those who can accept this invitation are requested to notify the management, that proper provision for their entertainment can be made.

PHYSICIANS ATTENTION!

Drug stores for sale on easy terms, etc., United States, Mexico and Canada. Drug store position. F. V. Kniest, Omaha. Nebraska.

NOTICE TO DOCTORS.

For Sale—A Wagner Four-plate Static Machine.

Guaranteed to be in *first- class* condition in every respect; no tarnish about it, as it has been handled carefully and given systematic attention. Get as good or better results from its use than when it was new.

Reason for selling is to get out of therapeutic x-ray work and do only surgical x-ray work. Have been in it ten years and developed an x-ray dermatitis and must quit. For price and other particulars, address or call on

J. R. Goodloe, M. D., Demopolis, Ala.

Personal Notes.

Dr. J. T. Manning of Lineville, Ala., was in the city on the 7th inst.

Dr. E. T. Fields, of Ensley, has returned from several months trip to Europe.

Dr. M. C. Thomas, of Bell Ellen, Ala., visited Birmingham on the third.

Dr. C. P. Martin spent a few hours in Birmingham on business on the second.

Announcement has been made of the marriage of Dr. W. E. Wright, of Wylam, to Miss Edwarda Otto Fischer, which is to occur October 21.

Dr. Howell T. Heflin went to New York via Savannah on the 9th inst. After a short stay there he will spend a few weeks in Baltimore doing post-graduate work.

Dr. A. F. Toole, of this city, and Secretary of the Jefferson County Medical Society, is to be married to Miss Kate McAlpine of Talladega September 30.

Dr. W. H. Sanders, State Health Officer of Montgomery, was in the city conferring with the local members of the State Board of Health a few days since.

The marriage of Dr. Julius B. Cooper, of Avondale, to Miss Alice Maud Adams, took place at the home of the bride, "Fernbank," this city, at 7:30 p. m., September 2.

The students of Dr. Byron Robinson are erecting a bronze bust to him. The affair is in the hands of Dr. Benjamin Orndoff, 2277 Wilcox Avenue, Chicago, Illinois.

Dr James S. McLester, 830 South Twentieth St., Birmingham, wishes to announce that he will be absent from his office for purposes of study October 1, 1907, to October 1, 1908.

Dr B. D. Sibley announces that he has moved his office to the second floor of the First National Bank Building, rooms 227 and 228, where he will continue the practice of eye, ear, nose and throat work.

Dr. H. N. Rooser of this city suffered a dislocation of the shoulder with a fracture of the neck of the humerus the first of September. His many friends will be glad to know that he is doing well, and hope for his speedy recovery.

Others doctors visiting Birmingham recently are: Dr. W. C. Head, Johns; Dr. W. T. Cocke, Livingston; Dr. Vann B. Potts, Scottsville; Dr. D. L. Wilkinson. Montevallo; Dr. Gunn, Calera; Dr. J. R. Pow, Maylene; Dr. J. T. Miller, Corona; Dr. W. A. Hayes, Helena; Dr. W. C. Williams, Gadsden, and Dr. Sam Nash, Brookwood.

THE USE OF BACTERIAL VACCINES.

Harry Britenstool of New York, has used with great success stock vaccines of mixed staphylococci in a number of cases, of which he submits the histories of three, all three patients having been subject for some time to recurrent abscesses or pustules.—*Medical Record*, August 8, 1908.

CONGENITAL UMBILICAL HERNIA, WITH REPORT OF A CASE.

Edward Magruder of Baltimore, Md., describes a case of congenital umbilical hernia of the variety in which the abdominal wall is grossly incomplete, the viscera being covered only with a thin covering derived from the amnion. The parents were both but fifteen years of age at the time of conception. The child had a solid umbilical tumor the size of an orange containing the right lobe of the liver. The infant lived only forty-eight hours. In 160 reported cases of eventration 126 were operated upon, 84 successfully.—*Medical Record*, Sept. 5, 1908.

Miscellaneous Notes.

PHILADELPHIA PHARMACY COLLEGE GIVES DEGREES.

For the first time in several years in this city the degree of Master of Pharmacy was conferred upon five distinguished men from different sections of the United States, who have attained distinction in the art of preparing medicines and drugs. Those who received this honor were Samuel W. Fairchild, of New York; Horatio Nelson Fraser, of New York; John F. Hancock, of Baltimore; S. A. D. Sheppard, of Boston, and William McIntyre, of Philadelphia.—*Evening Bulletin. Philadelphia.*

The Samuel W. Fairchild mentioned above is the treasurer of the well known firm of Fairchild Bros. & Foster.

ANTIKAMNIA CHEMICAL COMPANY TO BUILD STRUCTURE TO COST $75,000.

An improvement that will mean much to the section of Pine street just west of Twelfth street will be begun on September 1, when the Antikamnia Chemical Company, now located at 1624 Pine street, will erect at the northeast corner of Pine and Fourteenth streets, a five-story and basement building which will be used for manufacturing and commercial purposes. It will have a ground area of 81x109 feet, the latter frontage being on Fourteenth street, and will be constructed of brick and concrete. It will be modern in every detail, being provided with sprinkler system, fast elevators, etc., and will cost in the neighborhood of $75.000. The site has been owned by Mr. Frank A. Ruf, president of the company and a director in the Mercantile Trust Company, who has had it for the past seven years. It is improved with one, two and three story buildings of antiquated type, earning a rental in no way in keeping with the value of the property. The new building will adjoin the William McMillan heirs' property, a five-story factory building with a frontage of 60 feet. The Antikamnia Company will occupy all of the new structure, the upper floors being used for a can and box factory.

Its present quarters at 1624 Pine street are inadequate and the property on either side of it is so tied up that it can not be secured to extend the building. On this account the company expects to give up the building at the expiration of its present lease, which has a year or more to run, and to make the structure at Fourteenth and Pine its headquarters. If this is done the company will probably lease or buy the McMillan property and remodel it to conform with its new building, or it will erect a second building in the immediate neighborhood to cost about $50,000.

ABDOMINAL APPLICATIONS IN TYPHOID FEVER.

Success in handling a case of typhoid fever may be likened unto the steering of a ship, already in distress, through a dangerous rocky channel. Lucky be the typhoid fever patient in the hands of a cool, commonsense dictor. It is this sort of a physician who guides his patient through the tortuous, rocky channel of typhoid fever and finally brings him into a safe port.

The many-sidedness of typhoid fever gives it a large interest and calls for good judgment. What to do and when to do it, are questions largely determining a physician's success in this infection. The bowels are inflamed, the Peyer's patches being the foci of inflammation, and it is but the application of commonsense prinicples to seek for some means of combatting this intestinal inflammation.

Local applications prove efficacious elsewhere in inflammation—why not here? Applications with hygroscopic properties reduce inflammations in other tissues of the body and will do likewise in typhoid fever. The best of these is Antiphlogistine and its use in typhoid fever is demonstrable. It will tend to reduce the inflammation and thus contribute in making the typhoid patient comfortable and assist him in his return to health.

Antiphlogistine is applied over the abdomen to the thickness of an eighth of an inch and then covered with a suitable soft cloth. This is renewed twice daily.

This use of Antiphlogistine is a valuable adjunct in the usual treatment of typhoid fever and is of distinct assistance.—*Medical Era.*

Frederick Tiedeman, a German anatomist, founded angiecology. He was born in 1781, and died in 1860. To show that he was a "rara avis," he was given a professorship of anatomy on graduation from his alma mater. Subsequently he was called to the famous Heidelberg medical school, where he spent a long and useful life. He studied the arteries for seventeen years and in 1822 was published his atlas on the arteries. He entitled it "Tabulae arteriorum corporis humani." It originally sold at 168 marks ($42). At present one can find it advertised in the old German catalogues at 30 marks ($7.50). Tideman's work on the arteries is the standard text books of almost all countries. He was a man of wonderful persistence, patience and of rare ability. His ability cannot be questioned, when it is observed that his work on the arterial system has dominated medical science not far from a century (85 years). Tideman's work on the arterial system lies before me. It is practically correct as far as it extends, but it should be completed at least in the viscera. His arterial system of the viscera must be displaced by more complete illustrations. I am attempting to perform this by more complete dissections and detailed illustrations. The demands of surgery are beyond the days of Tiedeman. Tiedeman knew not the demands of applied anatomy of our day. The day of intestinal resection has arrived and the day of perityphlitis is at hand.

Renal surgery.—Tiedeman could not dream of its present perfection, although he lived in the city of Heidelberg, where Gustav Simon, professor of surgery in the same school with himself, first removed a kidney for ureteral fistula in August, 1868. And besides, when the next year 1869, immortal Hyrtl proved by corrosion anatomy that the kidney possessed end arteries. I revived this labor of Hyrtl's and conferred upon him the eponym "Hyrtl's exsanguinated renal zone." Tiedeman published other excellent works, but he will be longest remembered by his labors in angiecology.—*Byron Robinson.*

The powers of the physician should be employed in diagnosing and treating the patient and not in prophesying.—*Byron Robinson.*

The duty of a physician practically lies in the field of pathologic physiology.—*Byron Robinson.*

FOUR CASES OF PERFORATING ULCERS OF THE ALIMENTARY CANAL.

H. Beeckman Delatour of Brooklyn, New York, reports four cases of ulceration of different portions of the alimentary canal to emphasize the frequency of this accident. All the patients recovered under timely operation. The distinguishing feature of this accident is the sudden sharp onset of pain, with collapse. Following this is a period of apparent improvement, and the formation of protective adhesions, which may be ruptured by movements, resulting in general peritonitis.—*Medical Record,* August 29, 1908.

EARLY DIAGNOSIS OF CARCINOMA OF THE SIGMOID.

Edward Milton Foote of New York, says that carcinoma of the sigmoid is of interest to the surgeon because it grows slowly, and for a long time does not produce metastases. It is accessible, and situated in a part which can be sacrificed with impunity. Removal can be complete only in an early stage, before the lumbar glands have been attacked. The author quotes three illustrative cases. Early symptoms include pain, which, when obstruction has occurred, is in distinct peristaltic waves; increasing constipation; loss of weight; and obstruction. Tumor is not recognized early, nor is there anything to be gained from examination of the stools; diarrhea alternating with constipation is a late symptom, and blood in the stools is not always present. The disease is usually annular, and gives rise to symptoms of obstruction before more than an inch or two of the bowel has been involved. It is mild in type. Physical examination may not show much in a stout person. The bowel should be examined with the finger, through a tube, and with the endoscope. Pumping air or water into the rectum is of value, since the rectum will hold only one pint, while the sigmoid will hold an entire quart of liquid. The condition must be differentiated from chronic constipation and sigmoiditis. In sigmoiditis the condition is more markedly inflammatory. If the disease is in the left iliac fossa, with constipation for only six months, with local pain and impairment of strength, in a person after middle life, it is probably malignant. Treatment by freeing the tumor and the involved lymphatics, dividing so much of the mesocolon as to bring the affected intestine into the wound, stitching the loop of intestine into the peritoneum of the abdominal walls, and cutting off the protruding loop is without danger, and is the best procedure.—*Medical Record,* August 29, 1908.

PROTEID IRON PREPARATIONS OF THE NATIONAL FORMULARY.

We do not know how many of our readers are also readers of the "Critic and Guide," but we could wish that breezy periodical reached them all. Its editor has the scholarly mind, combined with a versatile wit, which makes the handling of abstruse topics interesting; his sermons are never without point and are never dry.

One of the more recent of these deals with a subject which we have somewhat treated in connection with the consideration of other themes, that is, the comparative worth of the National Formulary products and the worthy proprietaries in whose stead they are masquerading. There are a dozen good things which we could mention with no hesitation for which the Formulary product is a rank substitute and what Dr. Robinson says of pepto-mangan and its imitation could be said with equal truth and point of any one of them. He quotes from the recent findings of Prof. W. H. Harrison, of the Northwestern University School of Pharmacy, as reported in a paper read before the Chicago Branch of the American Pharmaceutical Association, but we do not need Prof. Harrison's expert evidence, we have bought and declined to buy these products in the open market and we know how filthy they may be, and are in some instances, and we know how lacking in uniformity they are. We can wish no worse thing for some of those who are active in the campaign for the recognition of substitution than that they be forced to take a few doses from some of the bottles we have seen and smelled! Pepto-Mangan we have known for years and we have always found it sweet, uniform and serviceable; can any one give us a rational reason why we should not use it? Or a rational reason for employing in its stead the rank substitutes which are offered? We must confess that we are of Dr. Robinson's mind in being unable to comprehend this furor for substitution which seems to have taken possession of many of our fellows, this phobia of proprietaries.

Are we to believe that honesty is not quite as liable to be found among proprietary manufacturers as in the high councils of the A. M. A.? Are we to discard the evidence of years of faithful work in practice, where our one effort has been to cure disease and relieve suffering, where we have sought studiously to use the very best, are we to

decide that those remedies which have done us good service have not done for us what we credited them with? It is a sorry time for the public when the profession really discovers that the agents it has been systematically employing have never been dependable; it is to be hoped that the public will never find it out if such a thing really happens for vaunted American Medicine will fall into greater disrepute than our most hated enemy has ever hoped for that day.

Personally we find much that is good among the proprietaries; much that is so vastly superior to the Formulary substitute that we have no inclination to shift allegiance. Certainly we do get results with pepto-mangan; it is most agreeable to patients, they like it and see that it benefits them; we would expect them to change physicians did we prescribe some of the liquor ferri peptonati cum mangano (N. F.) which we have seen!

We find it possible to administer arsenauro effectively where liquor auri et arseni bromidi (N. F.) is absolutely rejected.

It took but a few trials at the substitution of liquor cresolis comp. (N. F.) to convince us that in some respects it is not "practically identical with lysol" as represented.

Acetanilide appears in the Formulary in more than one combination; we have been unable to discover that the Formulary products are any less dangerous than those outside; acetanilide is acentanilide and the Formulary is not at all inaccessible to the laity; we have already seen one copy of the A. M. A. Manual of the Pharmacopeia and Formulary in the hands of a layman who is a chronic medicine taker and he had become quite familiar with it!

And where is all this foolishness to lead us? The situation would be absolutely funny were there not a very serious side to it. It is funny to see men, otherwise great, led by the nose by their inferiors, but only funny until the pathetic side reaches you.

When the St. Louis Medical Society was considering the adoption of a by-law making connection with a medical journal which published advertisements of products not on the "approval list." to constitute "gross misconduct," an amendment was sprung making it equally sinful to use these products in practice!

How quickly the saints began to squirm! More than one vigorously expressed himself as opposed to therapeutic dictation; he would use what he pleased; yet he would dictate to the journal and make its editor an irregular! Consistency is indeed a jewel!—*The Medical Fortnightly.*